

## MARGIN RESERVED FOR BINDING

V. S. No. 1.  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 11057

County

Village or City

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS.

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

July 19<sup>th</sup>

(Monthly)

(Day)

, 1910  
(Year)

7 AGE

yrs.

mos.

ds.

If LESS than  
1 day. hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.

(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)

So Balto. Md

PARENTS

10 NAME OF  
FATHER

Leopold Obrockie

11 BIRTHPLACE  
OF FATHER  
(State or country)

Germany

12 MAIDEN NAME  
OF MOTHER

Lottie Symanski

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leopold Obrockie

15

(Address)

Filed

July 21<sup>st</sup> 1915

R. B. Norton MD

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 24

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 20, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 19<sup>th</sup>, 1915, to July 20, 1915, that I last saw him alive on July 19<sup>th</sup>, 1915, and that death occurred on the date stated above, at m. The CAUSE OF DEATH \* was as follows:

Infantile  
Convulsions 6 hrs.

## Contributory

Secondary

J. B. Norton (Signature) (Duration) yrs. mos. ds.  
July 21, 1915 (Address) So Balto. M. D.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Holy Cross July 21, 1915

20 UNDERTAKER ADDRESS

Wm. J. Falkowski So Balto. Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthiness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fitter*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"; unqualified, is indefinite); *Tuberculosis of lungs*, *mени-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . .  
Aname, origin; "Cancer" is less definite; avoid use of  
"Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracinia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OR INJURY AND QUALITY AS ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OR AS PROBABLY SUCH, IF IMPOSSIBLE TO DETERMINE DEFINITELY. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 5 1915

INTER-A.U.V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

<b>1 PLACE OF DEATH</b>		11058	<b>STATE OF MARYLAND CERTIFICATE OF DEATH</b>
County <u>Anne Arundel</u>		Registered No. <u>21</u>	
Town <u>Germantown</u>			
Village or City <u>near Germantown</u>		(No. <u>419</u> )	St. <u>Ward</u> )
<b>2 FULL NAME</b> <u>Calvin David Adams</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
<b>PERSONAL AND STATISTICAL PARTICULARS</b>			
<b>3 SEX</b> <u>Male</u>	<b>4 COLOR OR RACE</b> <u>White</u>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word) <u>Widower</u>	<b>16 DATE OF DEATH</b> <u>July 5, 1915</u> (Month) (Day) (Year)
<b>6 DATE OF BIRTH</b> <u>March 24, 1850</u> (Month) (Day) (Year)		<b>17 I HEREBY CERTIFY</b> , That I attended deceased from <u>April 10, 1915</u> , to <u>July 5, 1915</u> , that I last saw him alive on <u>July 3, 1915</u> , and that death occurred on the date stated above, at <u>7 A.m.</u>	
<b>7 AGE</b> <u>65 yrs. 3 mos. 10 ds.</u>	If LESS than 1 day, .... hrs. OR ..... min. ?	The CAUSE OF DEATH* was as follows: <u>Bright Disease</u>	
<b>8 OCCUPATION</b> (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer).....		(Duration) <u>1 yrs. 0 mos. 0 ds.</u>	
<b>9 BIRTHPLACE</b> (State or country) <u>Shenandoah Valley, Va</u>		<b>Contributory</b> (Secondary) <u>Dr. C. Foster</u>	
<b>10 PARENTS</b>	<b>10 NAME OF FATHER</b> <u>David Adams</u>	(Duration) <u>1 yrs. 0 mos. 0 ds.</u>	
	<b>11 BIRTHPLACE OF FATHER</b> (State or country) <u>Unknown</u>	(Signed) <u>Dr. C. Foster</u> , M. D. <u>July 5, 1915</u> (Address) <u>Anne Arundel</u>	
	<b>12 MAIDEN NAME OF MOTHER</b> <u>Unknown</u>	State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIEN- TAL, SUICIDAL, or HOMICIDAL.	
	<b>13 BIRTHPLACE OF MOTHER</b> (State or country) <u>Unknown</u>	<b>18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)</b>	
	<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b> (Informant) <u>Geo W. Robbins</u>	At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.	
	(Address) <u>419 West St. Germantown</u>	Where was disease contracted, if not at place of death? Former or usual residence _____	
<b>15</b>	Filed <u>July 5, 1915</u> by <u>J. M. Welch</u>	<b>19 PLACE OF BURIAL OR REMOVAL</b> <u>Cedar Bluff</u>	
		<b>DATE OF BURIAL</b> <u>July 6, 1915</u>	
		<b>20 UNDERTAKER</b> <u>Chaney &amp; Sons</u>	
		ADDRESS <u>59 West St</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chlorotic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 11059  
 County Anne Arundel  
 Village or City Gambrills (No.)

STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registered No. 21

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Alfred Addison

PERSONAL AND STATISTICAL PARTICULARS					
3 SEX Male	4 COLOR OR RACE Black	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married			
6 DATE OF BIRTH Unknown		(Month)	(Day)	(Year)	
7 AGE 42		yrs.	mos.	ds.	If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION Farm Labour					
(a) Trade, profession, or particular kind of work....					
(b) General nature of industry, business, or establishment in which employed (or employer) Government Dairy Farm					
9 BIRTHPLACE (State or country) Maryland					
10 NAME OF FATHER Alfred Addison					
11 BIRTHPLACE OF FATHER (State or country) Maryland					
12 MAIDEN NAME OF MOTHER — Queen					
13 BIRTHPLACE OF MOTHER (State or country) Maryland					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant: Jesse Hawkins (Address): Mullensville Md					

MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH July 6		(Month)	(Day)	(Year) 1915	
17 I HEREBY CERTIFY, That I attended deceased from					
, 1915, to , 1915,					
that I last saw h. alive on , 1915,					
and that death occurred on the date stated above, at m.					
The CAUSE OF DEATH* was as follows: accident. due to explosion of gun powder while at work grinding powder					
(Duration) yrs. mos. ds.					
Contributory (Secondary)					
(Duration) yrs. mos. ds.					
(Signed) Dr. Joyce Justice J. E. Pace M. D. (Address) 716, Miller'sville Md					
716 State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.					
Where was disease contracted, if not at place of death?					
Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL Macedonia Cemetery DATE OF BURIAL 7/16, 1915					
20 UNDERTAKER a a co ADDRESS 32 northeast st Annapolis Md.					

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Old Age," "Shock," "Træmia," "Weakness," etc., when surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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<b>RECEIVED</b>
AUG 6 1915
<b>BUREAU, V.S.</b>

## MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11060

County

Anne Arundel

(69)

Village or City

Shady Side (No.)

2 FULL NAME

Vera Anna Avery

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female white

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

August 15, 1915

(Month) (Day) (Year)

7 AGE

5 yrs.

10 mos.

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

Infant

9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

10 NAME OF FATHER

Walter Avery

11 BIRTHPLACE OF FATHER

Maryland

12 MAIDEN NAME OF MOTHER

Mary A. Randall

13 BIRTHPLACE OF MOTHER

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Avery

(Address)

Shady Side Ms

15

Filed July 3, 1916.

Geo T Dent

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 26

St; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 2nd

(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from  
June 29, 1915, to July 2nd, 1915,  
that I last saw her alive on July 2nd, 1915,

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH \* was as follows:

Epilepsy - edema  
of lungs

(Duration) yrs. mos. ds.

Contributory  
Secondary

Lester L Howard

(Duration) yrs. mos. ds.

(Signed)

July 2, 1915 (Address) Shady Side, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL OR HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place  
of death yrs. mos. ds. In the  
State, yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

St Johns Chapel

DATE OF BURIAL

July 3, 1916

20 UNDERTAKER

Harding &amp; Hunt

ADDRESS

Galloways

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

11061

County Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 2

Village or City 3rd district (No.)

6LP

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME Jacob Barnes

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE Colored.	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
------------	--------------------------	---

6 DATE OF BIRTH About	(Month)	(Day)	(Year) 1851
-----------------------	---------	-------	-------------

7 AGE About 64	yrs.	mos.	ds.	If LESS than t day, hrs. OR min. ?
----------------	------	------	-----	--

8 OCCUPATION (a) Trade, profession, or particular kind of work Farm laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Unknown
---

10 NAME OF FATHER Unknown
---------------------------

11 BIRTHPLACE OF FATHER (State or country) Unknown
--

12 MAIDEN NAME OF MOTHER Unknown
----------------------------------

13 BIRTHPLACE OF MOTHER (State or country) Unknown
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant Henry Stephens
---

Address Ellicott Md.
----------------------

Filed July 15, 1915 J. S. Bellingslea
---------------------------------------

REGISTRAR
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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July	(Month)	15 (Day)	1915 (Year)
-----------------------	---------	----------	-------------

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1915, to July 15, 1915, that I last saw him alive on July 15, 1915, and that death occurred on the date stated above, at 3 P.M., The CAUSE OF DEATH* was as follows:
--

Hemorrhage in the Brain.
--------------------------

(Duration) 4 hours yrs. mos. ds.
----------------------------------

Contributory Asteria - Salivary (Secondary)
---

(Duration) 3 yrs. mos. ds.
----------------------------

(Signed) James S. Bellingslea, M.D.
-------------------------------------

July 15, 1915 (Address) Ellicott Md.
--------------------------------------

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
--

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
---

At place of death yrs. mos. ds. In the State yrs. mos. ds.
--

Where was disease contracted, if not at place of death?
---

Former or usual residence
---------------------------

19 PLACE OF BURIAL OR REMOVAL Magrath Col. Church	DATE OF BURIAL July 16, 1915
---	------------------------------

20 UNDERTAKER Harry Vodery	ADDRESS Balto. Md.
----------------------------	--------------------

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocer*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cervicospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritacraum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Cerebral"), "Senile," etc.), "Drowsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *ictalus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11062

County A. Co.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 24

Village or City Brooklyn P. D.

2 FULL NAME Sarah E. Brooks

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Black

4 COLOR OR RACE

5 SINGLE  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word) Married

6 DATE OF BIRTH

7 AGE

48 yrs.

(Month) Sept.

(Day) 17

(Year) 1867

If LESS than  
1 day, hrs.  
min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work Domestic
- (b) General nature of industry business, or establishment in which employed (or employer) Self

9 BIRTHPLACE

(State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER

William Dotson

11 BIRTHPLACE OF FATHER

(State or country) A. A. Co.

12 MAIDEN NAME OF MOTHER

Sarah E. Bottom

13 BIRTHPLACE OF MOTHER

(State or country) County

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marie A. Brooks

(Address) Brooklyn Md.

15

Filed July 19<sup>th</sup>, 1915

J. B. Harton, M.D.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 19<sup>th</sup>, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 2<sup>nd</sup>, 1915, to July 19<sup>th</sup>, 1915,that I last saw her alive on July 19<sup>th</sup>, 1915,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Dental extraction  
Acute Indigestion  
Duration 10 mos. 10 ds.  
Contributory Cause Secondary  
Burial place B. Norton, Md.  
(Signed) Mrs. B. Norton, Md.  
(Address) 33 Pulaski St.  
(Date) July 19<sup>th</sup>, 1915

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. de. In the State, yrs. mos. de.

of death Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

John &amp; Joadon July 21, 1915

20 UNDERTAKER

Judson Cemetery, Balto.

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

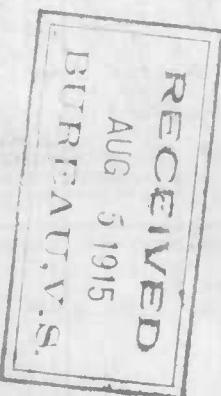
**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery salesman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

gesis

(name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 11063  
 County *A A*  
 Village or City *Rivells Station* (No.)

STATE OF MARYLAND  
 CERTIFICATE OF DEATHRegistration Dist. No. *21*

St.; Ward)

[If death occurred in  
 a hospital or institution,  
 give its NAME instead  
 of street and number.]2 FULL NAME *Frank A. Brown*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDDED OR DIVORCED (Write the word) <i>Single</i>
6 DATE OF BIRTH <i>July 7 1895</i> (Month) (Day) (Year)		
7 AGE <i>20 yrs. - mos. 23 ds.</i> If LESS than 1 day, hrs. OR min.?		

8 OCCUPATION  
 (a) Trade, profession, or  
 particular kind of work *Farmers*  
 (b) General nature of industry  
 business, or establishment in  
 which employed (or employer)

9 BIRTHPLACE  
 (State or country) *Baltimore Md*10 NAME OF  
 FATHER *George Brown*11 BIRTHPLACE  
 OF FATHER  
 (State or country) *Baltimore Md*12 MAIDEN NAME  
 OF MOTHER *Annie Caughwell*13 BIRTHPLACE  
 OF MOTHER  
 (State or country) *Baltimore Md*14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) *John Johnson*  
 (Address) *Carysot A A Co Md*15 Filed *Aug 2 1915* — *JMS Welch*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 10*  
 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
*, 191 , to , 191 ,*

that I last saw h alive on , 191 ,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

*accidentally fell by running  
 into an Aut truck while riding  
 on a bicycle**immediate. Fractured skull*Contrebutary  
 Secondary*William F. Myrick, Coroner*  
 (Signed) *Aug 2 1915* (Address) *Chesapeake Md*\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
 CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
 SUICIDAL or HOMICIDAL18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
 OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,  
 if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*St Annes Cemt Aug 2 1915*

20 UNDERTAKER ADDRESS

*Jas S. Taylor Son Minneapolis*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . .  
(name origin; "Cancer" is less definite; avoid use of  
"Humor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Masmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 6 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Anne Arundel

11064

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 20

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Owensville (No. ....)2 FULL NAME Cetelle Butler

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Negro5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

March 7, 1899  
(Month) (Day) (Year)

7 AGE

16 yrs. 5 mos. 18 ds.If LESS than  
1 day, ..... hrs.  
OR ..... min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of workNone(b) General nature of industry,  
business, or establishment in  
which employed (or employer)None

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Elza Butler

11 BIRTHPLACE OF FATHER

(State or country)

Prince George Co., Md.

12 MAIDEN NAME OF MOTHER

Suzette Peters

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Morrison

(Address)

Lothian Md.

15

Filed July 29, 1915 Mclane Carroll Jr. & Co.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 28, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
I did not attend, 1915, to 1915,

that I last saw h. alive on 1915,

and that death occurred on the date stated above, at 1915 m.

The CAUSE OF DEATH\* was as follows:

I believe phthisis pul-  
monary

(Duration) yrs. mos. ds.

Contributory Unknown  
Secondary

(Duration) yrs. mos. ds.

(Signed) MacLean Gaywood, M. D.  
July 28, 1915 (Address) West River Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT DEATHS, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Mt. ZionDATE OF BURIAL  
July 29, 1915

20 UNDERTAKER

John ThomasADDRESS  
Tolleson Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houscorker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 7 1915
BUREAU, U.S.A.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH 11065  
County a. a. led

Village or City Annapolis Md No. 27

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sarah Butler

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE Colored	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
--------------	-------------------------	---

6 DATE OF BIRTH July	15	1839
(Month)	(Day)	(Year)

7 AGE 56 yrs. 0 mos. 7 ds.	If LESS than 1 day, hrs. OR min. ?
----------------------------	------------------------------------

8 OCCUPATION (a) Trade, profession, or particular kind of work. Housewife	(b) General nature of industry, business, or establishment in which employed (or employer)
---	--

9 BIRTHPLACE (State or country) Annapolis Md
--

10 NAME OF FATHER Unknown
---------------------------

11 BIRTHPLACE OF FATHER (State or country) Unknown
--

12 MAIDEN NAME OF MOTHER Unknown
----------------------------------

13 BIRTHPLACE OF MOTHER (State or country) Unknown
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Butler Jr.

(Address) 27 Scotts Court

15 Filed July 20, 1915 - J. M. Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 18, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1915, to July 18, 1915,

that I last saw her alive on July 16, 1915, and that death occurred on the date stated above, at 12-30 P.M.

The CAUSE OF DEATH\* was as follows:

Acute nephritis

(Duration) yrs. mos. 24 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) R. S. Miller, M. D.

July 14, 1915 (Address) 28 Patterson

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Brewer Hill Cemetery

DATE OF BURIAL July 21<sup>st</sup>, 1915

20 UNDERTAKER Samuel Allen

ADDRESS 82 N. W. St.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Contractor*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauschepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Epidemic cerebrospinal meningitis*"; *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lung, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchomnemomia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 6 1915
BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County..... a a

11066

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

Village or City Annapolis Bay (No.)

164

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

William Henry Butler

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED(Write the word)  
Single

## 6 DATE OF BIRTH

Jan 5, 1915

(Month) (Day) (Year)

## 7 AGE

yrs. 6 mos. 15 ds.

11 LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.....(b) General nature of industry  
business, or establishment in  
which employed (or employer).....

None

## 9 BIRTHPLACE

(State or country) A. A. Co. Md.

## PARENTS

## 10 NAME OF FATHER

Charles Butler

## 11 BIRTHPLACE OF FATHER

(State or country) A. A. Co. Md.

## 12 MAIDEN NAME OF MOTHER

Darsley Gross

## 13 BIRTHPLACE OF MOTHER

(State or country) A. A. Co. Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Darsley Butler

(Address) Carl Court A. A. Co. Md.

## 15

Filed July 21, 1915 - J. M. Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

July 20<sup>th</sup>, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 18<sup>th</sup>, 1915, to July 20<sup>th</sup>, 1915, that I last saw him alive on July 19<sup>th</sup>, 1915, and that death occurred on the date stated above, at 6 p.m.

The CAUSE OF DEATH \* was as follows:

Gastro Enteritis  
Several days  
Duration yrs. mos. ds.  
Contributory Secondary  
Gradual by hanstion  
John Ridout  
July 18, 1915 Address

(Signed) John Ridout  
Annapolis, Md.

\* State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. m. ds. In the State, yrs. m. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Annapolis, Md.

## DATE OF BURIAL

July 21, 1915

## 20 UNDERTAKER

Jas. S. Taylor &amp; Sons

## ADDRESS

Annapolis

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary engineer*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business, or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæma," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNADING INK—THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

11067

County A aSTATE OF MARYLAND  
 CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Annapolis

(No.)

Franklin

15a

St.; 2 Ward)[If death occurred in  
 a hospital or institution,  
 give its NAME instead  
 of street and number.]2 FULL NAME John Pierce Campbell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
 MARRIED,  
 WIDOWED  
 OR DIVORCEDMARRIED  
 (Write the word)

6 DATE OF BIRTH

Sept

(Month)

15

(Day)

, 1867

(Year)

7 AGE

44

yrs.

9

mos.

22

ds.

If LESS than  
 1 day, \_\_\_\_ hrs.  
 OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or  
 particular kind of work(b) General nature of industry  
 business, or establishment in  
 which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
 FATHER11 BIRTHPLACE  
 OF FATHER

(State or country)

12 MAIDEN NAME  
 OF MOTHER13 BIRTHPLACE  
 OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary B. J. Campbell

(Address)

15

Filed July 9 1915

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

(Month)

7

(Day)

, 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw h — alive on

and that death occurred on the date stated above, at about 1 P.m.

The CAUSE OF DEATH \* was as follows:

Suicide by shooting

(Duration) yrs. mos. ds.

Contributory  
 Secondary(Signed) Wm. F. Murray, Coroner (Duration) yrs. mos. ds.July 1915 (Address) Anne Arundel, Maryland\* State the DISEASE CAUSING DEATH, if in deaths from VIOLENT  
 CAUSES, state (1) MEANS OF INJURY; and (2), whether ACCIDENTAL,  
 SUICIDAL OR HOMICIDAL18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
 OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the \_\_\_\_\_

of death yrs. mes. ds. State, yrs. mos. ds.

Where disease contracted,

If not at place of death? \_\_\_\_\_

Former or  
 usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Winchester Va DATE OF BURIAL  
July 9, 1915

20 UNDERTAKER

Jas. S. Taylor Sons ADDRESS  
Annapolis

Tree

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton-mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cod* *mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired* 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges

(name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemic," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "*Contributory*" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <i>a - a -</i>		11068	STATE OF MARYLAND CERTIFICATE OF DEATH		
			Registration Dist. No. 21		
Village or City <i>Annapolis</i> (No. 57)	<i>Washington</i>		St. 4	Ward	[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <i>John Henry Chew</i>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Male</i>	4 COLOR OR RACE <i>Colored</i>	5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word) <i>Widower</i>			
6 DATE OF BIRTH <i>July 7</i>		If LESS than 1 day, .... hrs. or .... min?			
7 AGE <i>82 yrs - 7 mos - ds</i>					
8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>Steward</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>Retired</i>					
9 BIRTHPLACE (State or country) <i>Prince George Co Md</i>					
10 NAME OF FATHER <i>unknown</i>					
11 BIRTHPLACE OF FATHER (State or country) <i>unknown</i>					
12 MAIDEN NAME OF MOTHER <i>unknown</i>					
13 BIRTHPLACE OF MOTHER (State or country) <i>unknown</i>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Elizabeth Chew</i> (Address) <i>5-7 Washington St.</i>					
15 Filed <i>July 15 1915 - Mrs Welch</i>					
16 MEDICAL CERTIFICATE OF DEATH DATE OF DEATH <i>July 14 1915</i> (Month Day Year) I HEREBY CERTIFY, That I attended deceased from <i>March 11 1915</i> , to <i>July 13 1915</i> , that I last saw him alive on <i>July 13 1915</i> , and that death occurred on the date stated above, at <i>620A m.</i> The CAUSE OF DEATH* was as follows: <i>Gastric Inflammation</i> Contributory <i>Smile Nervous</i> (Duration) yrs. mos. ds. <i>Chloroform</i> (Duration) yrs. mos. ds. (Signed) <i>John Garcia</i> M. D. 7-15, 1915 (Address) <i>Annapolis Md</i>					
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds Where was disease contracted, if not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <i>Brewerhill Cemt.</i> DATE OF BURIAL <i>7-17 1915</i>					
20 UNDERTAKER <i>E.H.B Parker &amp; Son</i> ADDRESS <i>92 West St.</i>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

Dr Garcia

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosches*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthme," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Miasma," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

11069

1 PLACE OF DEATH County <u>Duke</u>		STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Charles Station</u>		Registration Dist. No. <u>21</u>		
2 FULL NAME <u>Frances M Clark</u>		St.; Ward)		
[If death occurred in a hospital or institution, give its NAME instead of street and number.]				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Widow</u>	MEDICAL CERTIFICATE OF DEATH	
6 DATE OF BIRTH <u>Nov 8</u>		(Month) (Day) (Year) <u>1913</u>	16 DATE OF DEATH <u>July 16</u>	(Month) (Day) (Year) <u>1915</u>
7 AGE <u>1 yrs. 8 mos. 8 ds.</u>		If LESS than 1 day, hrs. OR min. ?	I HEREBY CERTIFY, That I attended deceased from <u>July 16</u> , 1915, to <u>July 16</u> , 1915,	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Miscellaneous</u>		that I last saw her alive on <u>July 16</u> , 1915,		and that death occurred on the date stated above, at <u>9 A.M.</u>
(b) General nature of industry business, or establishment in which employed (or employer) <u>Miscellaneous</u>		The CAUSE OF DEATH * was as follows: <u>Miscellaneous</u>		
9 BIRTHPLACE (State or country) <u>Maryland</u>		Contributory Secondary		
10 NAME OF FATHER <u>Duke Clark</u>		(Duration) yrs. mos. ds.		
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		(Signed) <u>Thomas A. Bradbury</u> , M. D.		
12 MAIDEN NAME OF MOTHER <u>Sonata Clark</u>		(Address) <u>1 New Bedford</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Duke Clark</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence		
(Address) <u>Second &amp; 7th</u>		In the State, yrs. mos. ds.		
15 Filed <u>July 17, 1915</u> <u>Thomas A. Bradbury</u> Deputy REGISTRAR		19 PLACE OF BURIAL OR REMOVAL <u>Maryland</u> DATE OF BURIAL <u>July 18, 1915</u>		
		20 UNDERTAKER <u>Poy Stephney</u> ADDRESS <u>Bethel</u>		

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges*, peritonacum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer," is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Colic," "Lapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, U. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11070

County Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Earleigh Heights (No.)

2 FULL NAME

Mary E. H. Clopton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	Cape white	Single

6 DATE OF BIRTH

Oct 29, 1913

(Month) (Day) (Year)

7 AGE

2 9 8

yrs. mos. ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of Industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Anne Arundel Co Md

PARENTS

10 NAME OF FATHER

Reuben Clopton

11 BIRTHPLACE OF FATHER  
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Mary Howard

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Reuben Clopton (father)

(Address)

Earleigh Heights Md

15

Filed July 9, 1915 J. S. Bellinger

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 7

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1915, to July 7, 1915,  
that I last saw her alive on July 5, 1915,  
and that death occurred on the date stated above, at 5 o'clock m.

The CAUSE OF DEATH\* was as follows:

Typhoid

(Duration) 2 yrs. 9 mos. 8 ds.

Contributory  
Secondary

Pennsylvania

(Duration) yrs. mos. ds.

(Signed) J. H. Brown

, 1915 (Address) 121 W. West St., M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Earleigh Heights Baptist Ch.

DATE OF BURIAL

July 9, 1915

20 UNDERTAKER

Armstrong Denny Co

ADDRESS

715 Light St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

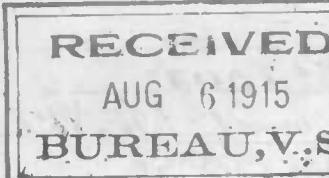
**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 d.s.*; *Bronchopneumonia* (secondary), *10 d.s.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered to your satisfaction, it will prevent further correspondence. At the date's essential and must be obtained before the certificate is officially filed.



## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH County		11071 Winchester St. Annapolis	STATE OF MARYLAND CERTIFICATE OF DEATH
Village or City			Registration Dist. No. 21
2 FULL NAME		Pet Fridley Cochrane	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	Widow
6 DATE OF BIRTH			
7 AGE		Feb 18 1861 (Month) (Day) (Year)	It LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)			
X Housewife			
9 BIRTHPLACE (State or country)			
Olive			
10 NAME OF FATHER			
John Fridley			
11 BIRTHPLACE OF FATHER (State or country)			
Va			
12 MAIDEN NAME OF MOTHER			
Alma Stevens			
13 BIRTHPLACE OF MOTHER (State or country)			
Va			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)			
(Address)		Edwin J. Cochrane U.S. M.A. Annapolis Md.	
15 Filed July 7, 1915 - Mrs. Welch			
REGISTRAR			
16 MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH July 5, 1915 (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from May 12, 1915, to July 5, 1915, that I last saw her alive on July 4, 1915, and that death occurred on the date stated above, at 6 P.M.			
The CAUSE OF DEATH was as follows: Bright's Disease			
(Duration) yrs. 4 mos. 0 ds.			
Contributory Secondary			
(Duration) yrs. 0 mos. 0 ds.			
(Signed) Dr. C. Force, M.D.			
July 7, 1915 (Address) Annapolis			
State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ of death _____ yrs. _____ mos. _____ ds. in the _____ State, _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death ? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL			
St. James' Church July 8, 1915			
DATE OF BURIAL			
20 UNDERTAKER ADDRESS			
Joe T. Taylor Sons Annapolis			

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

gosis

*peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . .  
("name origin"; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *cataract*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED	AUG 6 1915
BUREAU, V.S.	

**N. B.—** Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11072

County..... a. 9

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 24

Village or City Santa Bay &amp; Church

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Valley Virginia Cornell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE W	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single
--------------	-------------------	--

6 DATE OF BIRTH

June 3<sup>rd</sup>, 1915  
(Month) (Day) (Year)

7 AGE

yrs. 1 mos. X 9 ds. If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis W. Cornell Jr.

(Address) Curtis Bay Md.

15 Filed July 13<sup>th</sup>, 1915 T. B. Norton M.D.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 12, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 1<sup>st</sup>, 1915, to July 12<sup>th</sup>, 1915, that I last saw her alive on July 11<sup>th</sup>, 1915, and that death occurred on the date stated above, at 6:30 m.

The CAUSE OF DEATH \* was as follows:

Acute Gastric Enteritis

(Duration) yrs. mos. 12 ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed) William J. C. Curtis Bay Md. M. D.

July 12, 1915 (Address)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cedar Hill Cemetery July 13, 1915

20 UNDERTAKER

H. J. Mc Flynn ADDRESS 1422 Light St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (o) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonacum*, etc.; *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death); *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

11073

County Anne ArundelSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Annapolis (No. Franklin)St. 2 Ward)[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]2 FULL NAME J. Marshall Coughly

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word) Single6 DATE OF BIRTH July 29, 1883

(Month) (Day) (Year)

7 AGE 31 yrs. 11 mos. 29 ds.If LESS than  
1 day, hrs.  
OR min.?8 OCCUPATION Clerk in Bank(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer) Baltimore Md9 BIRTHPLACE Baltimore Md  
(State or country)10 NAME OF FATHER Jno H. Coughly11 BIRTHPLACE OF FATHER Balto. Md.  
(State or country)12 MAIDEN NAME OF MOTHER Laura V. Mittelat13 BIRTHPLACE OF MOTHER Balto. Md.  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno H. Coughly(Address) Lincoln Ave 2244  
Baltimore Md

15

Filed July 2, 1915 - Jno H. Coughly

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 1, 1915

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw h — alive on — , 191 — ,

and that death occurred on the date stated above, at about 8 p.m.

The CAUSE OF DEATH \* was as follows:

Suicide  
by shooting

(Duration) yrs. mos. ds.

Contributory  
Secondary(Signed) W. F. Munroe, Coroner (Duration) yrs. mos. ds.(Address) Annapolis Md July 2, 1915\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL OR HOMICIDAL18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. mos. ds.Where disease contracted,  
if not at place of death? \_\_\_\_\_ In the  
State, \_\_\_\_\_ yrs. mos. ds.Former or  
usual residence \_\_\_\_\_19 PLACE OF BURIAL OR REMOVAL Balto. MdDATE OF BURIAL July 2, 191520 UNDERTAKER Jas. J. Taylor, SonADDRESS Annapolis

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæma," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915.

BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

11054

11054

Anne Arundel

Millersville

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Bertha Creek

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant)

15

Filed

July 6

, 1915

19

REGISTRAR

I

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 6, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1915, to July 5, 1915, that I last saw her alive on July 4, 1915, and that death occurred on the date stated above, at 7 a.m. The CAUSE OF DEATH \* was as follows:

Chest Cough

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Thomas H. Branham, M. D.  
July 6, 1915 (Address) 112 Main Street

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_  
of death yrs. mos. ds.  
Where was disease contracted,  
if not at place of death?

In the State, yrs. mos. ds.  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Holy Cross Cemetery July 6, 1915

20 UNDERTAKER

John Fahey ADDRESS  
Baltimore

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"; unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always specify all diseases resulting from child birth or miscarriage as "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 6 1915

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		11075
County		Anne Arundel
Village or City		McKendree (No.)
2 FULL NAME Charles Creek		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX Male	4 COLOR OR RACE Black	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)
6 DATE OF BIRTH April 1, 1837		(Month) (Day) (Year)
7 AGE 78 yrs 4 mos 0 ds.	If LESS than 1 day, hrs. OR min.?	
8 OCCUPATION Farm laborer until 10 years ago. Since, None (a) Trade, profession, or particular kind of work.		
(b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) Md.		
PARENTS	10 NAME OF FATHER Henry Creek	
	11 BIRTHPLACE OF FATHER (State or country) Md.	
	12 MAIDEN NAME OF MOTHER Unknown	
	13 BIRTHPLACE OF MOTHER (State or country) Md.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant) Agnes Brown	(Address) McKendree, Md.	
15 Filed Aug. 1st, 1915	A. N. Perine Lincol REGISTRAR	

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 26

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 31, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from for many years, 191 to 191,

that I last saw him alive on July 15, 1915, and that death occurred on the date stated above, at 9:50 A.M.

The CAUSE OF DEATH\* was as follows:

Arterio-Sclerosis

(Duration) Many years yrs mos ds.

Contributory Secondary Valvular disease B.  
Heart

(Duration) 2 yrs mos ds.

(Signed) A. N. Perine, M. D.  
Aug. 1, 1915 (Address) McKendree, Md.

\* State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence \_\_\_\_\_19 PLACE OF BURIAL OR REMOVAL  
Farm of Mrs. Marion Darnell  
near Bristol, Md. DATE OF BURIAL Aug. 1st, 1915

20 UNDERTAKER Robt. J. Wood ADDRESS Friendship, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic vulvar heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) disease need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Tebility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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RECEIVED
AUG 6 1915
BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH

11076

County

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 24

Village or City

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6

6 DATE OF BIRTH

(Month)

(Day)

(Year)

7 AGE

yrs.

mos.

If LESS than  
1 day.....hrs.  
ds. OR min.?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

## PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed July 4<sup>th</sup>, 1915

T. B. Norton, M.D.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 4, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, THAT I attended deceased from

July 4, 1915, to July 4, 1915,

that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.,

The CAUSE OF DEATH\* was as follows:

Premature Birth

Contributory  
Secondary

Thomas B. Norton, M.D.

(Signed) (Address) S. Balto. Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cedar Hill July 4, 1915

20 UNDERTAKER Samuel Trowse father ADDRESS Brooklyn

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

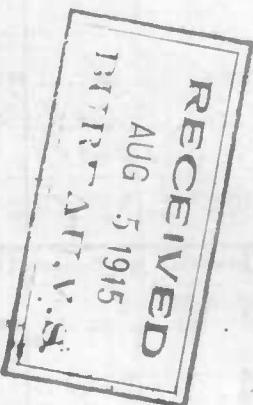
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County	11140 <i>A. A. (185) CD</i>	STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. 24
Village or City	<i>3rd Dist. R. A. C. adjacent to So Ballard Ward</i>	[If death occurred in a hospital or institution, give its NAME instead of street and number.]
<b>2 FULL NAME</b>		<i>Joseph F. Cruz</i>
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WOOED, OR DIVORCED (Write the word)
Male	White	Married
6 DATE OF BIRTH	April 4, 1874 (Month) (Day) (Year)	
7 AGE	41 yrs. 3 mos. 9 ds.	If LESS than 1 day, ____ hrs. OR ____ min. ?
8 OCCUPATION	Seaman W. S. Coast Guard	
(a) Trade, profession, or particular kind of work	(b) General nature of industry, business, or establishment in which employed (or employer)	
9 BIRTHPLACE (State or country)	Fayal-Azores	
10 NAME OF FATHER	Unknown	
11 BIRTHPLACE OF FATHER (State or country)	Unknown	
12 MAIDEN NAME OF MOTHER	Unknown	
13 BIRTHPLACE OF MOTHER (State or country)	Unknown	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address)	Capt. J. M. Nash— 215. Coast Guard Sta. Balto. Md. July 12, 1915	
15 Filed	July 12, 1915 T. B. Heron M.D.	
REGISTRAR		
MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH	July 12, 1915 (Month) (Day) (Year)	
I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,		
that I last saw h. alive on _____, 191____,		
and that death occurred on the date stated above, at 12:00 p.m.		
The CAUSE OF DEATH* was as follows:		
<i>Fractured Skull &amp; Concussion of Brain Caused by accident</i>		
Contributory Secondary		
(Duration) <i>James F. Foster Jr.</i> (Address) <i>Brooklyn, N.Y.</i>		
(Signed) <i>James F. Foster Jr.</i> (Address) <i>Brooklyn, N.Y.</i>		
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
At place of death yrs. mos. ds. In the State yrs. mos. ds.		
Where was disease contracted, if not at place of death?		
Former or usual residence		
19 PLACE OF BURIAL OR REMOVAL		
London Park		
DATE OF BURIAL July 15, 1915		
20 UNDERTAKER		
H. E. Hughes		
ADDRESS Balto. Md.		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Maugger," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 5 1915

BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

11077

County Anne Arundel

Village or City Churchton (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 26

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Lydia C. Dawson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fem. white

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Mar. 25, 1864  
(Month) (Day) (Year)

7 AGE

51 yrs. 3 mos. 27 ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work At home  
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

## PARENTS

10 NAME OF FATHER

Basil A. Owings

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Martha Ann Massey

13 BIRTHPLACE OF MOTHER

(State or country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed July 22, 1915

Geo T. Dent  
Sep Local

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 22, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1915, to July 22, 1915, that I last saw her alive on July 22, 1915, and that death occurred on the date stated above, at 8:45 A.M. The CAUSE OF DEATH \* was as follows:

Parcimoma of Stomach

(Duration) yrs. 6 mos. 0 ds.

Contributory  
Secondary

(Duration) yrs. 0 mos. 0 ds.

(Signed)

Geo T. Dent, M. D.  
July 22, 1915 (Address) Churchton

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Where was disease contracted,  
If not at place of death?Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

St. John's Chapel Shady Side, Md. July 23, 1915

20 UNDERTAKER

Hardenly &amp; Hand Yellowgate, Md.

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Husband's wife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sorcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masstles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethæus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 6 1915

BUREAU.V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County		11078 <i>Anne Arundel</i>
Village or City		<i>Pumphrey Md</i>
2 FULL NAME		<i>George Edwin Dixon</i>
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Single</i>
6 DATE OF BIRTH <i>May 4, 1914</i>		If LESS than 1 day,.....hrs. OR min. ?
7 AGE <i>1 / 26</i>	Yrs. .... mos. .... ds.	
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>at home</i> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <i>Maryland</i>		
10 NAME OF FATHER <i>Edwin Eldridge Dixon</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>		
12 MAIDEN NAME OF MOTHER <i>Frances Virginia Phipps</i>		
13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Frances Virginia Dixon</i> (Address) <i>Pumphrey Md</i>		
15 Filed <i>July 2, 1915</i>		Certified by <i>C. R. Wm. L. Johnson</i>

STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <i>23</i>		
St.: Ward)		
[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH <i>July 1st, 1915</i>	(Month)	(Day)
17 I HEREBY CERTIFY That I attended deceased from <i>June 25, 1915</i> to <i>July 1st, 1915</i>		
that I last saw him alive on <i>July 1st, 1915</i>		
and that death occurred on the date stated above, at <i>10:25 P.M.</i>		
The CAUSE OF DEATH* was as follows: <i>Eleon Colitis</i>		
(Duration) <i>9 days</i>		
Contributory Secondary	<i>Same</i>	(Duration) <i>9 days</i>
(Signed) <i>C. R. Wm. L. Johnson</i> , M. D. <i>July 2, 1915</i> (Address) <i>Hanover Maryland</i>		
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
At place of death yrs. mos. ds. In the State yrs. mos. ds.		
Where was disease contracted, if not at place of death?		
Former or usual residence.		
19 PLACE OF BURIAL OR REMOVAL <i>Edwards Chapel Cemetery</i>		DATE OF BURIAL <i>July 3, 1915</i>
20 UNDERTAKER <i>Albert Adams</i>		ADDRESS <i>Annapolis Rd</i>

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Maager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Coagential," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Mastasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED	JUL 8 1915	BUREAU, U.S.
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## MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH

11079

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

County AA

Village or City Marley (No.)

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Leonora Ronaldson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
H	W	Single
6 DATE OF BIRTH		
April 25 <sup>th</sup>		1915
(Month)	(Day)	(Year)
7 AGE		
— yrs.	2 mos.	13 ds.
If LESS than 1 day, hrs. OR min.?		

8 OCCUPATION	(a) Trade, profession, or particular kind of work
	—
	(b) General nature of industry business, or establishment in which employed (or employer)
9 BIRTHPLACE	(State or country)
AA County	

10 NAME OF FATHER	Joshua Herbert Donaldson
11 BIRTHPLACE OF FATHER	Md
12 MAIDEN NAME OF MOTHER	Mamie Lee Warfield
13 BIRTHPLACE OF MOTHER	AA County

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Married Lee Warfield

(Address) Marley

15 Filed July 8, 1915  
Signed by Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 8<sup>th</sup>, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to July 8<sup>th</sup>, 1915, that I last saw her alive on July 8<sup>th</sup>, 1915, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH \* was as follows:

Disecolitis

(Duration) yrs. mos. 8 ds.

Contributory  
Secondary

(Signed) Martha A. Morris, M.D.  
(Address) Barnburner Md.  
(Duration) yrs. mos. ds.

July 8, 1915

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place  
of death yrs. mos. ds.  
Where was disease contracted,  
if not at place of death?  
Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL  
Hannay Burial Ground July 9<sup>th</sup>, 1915  
DATE OF BURIAL

20 UNDERTAKER  
ADDRESS  
Crushey - Dailey Belknap

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saxsman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Ram laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Houseward*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Tuberculosis*, *Pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL sepiachroma," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		11080	STATE OF MARYLAND CERTIFICATE OF DEATH	
County		Anne Arundel		
Village or City		Earleigh Heights		
2 FULL NAME		Dorsey		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	S	
Male	Black	Single		
6 DATE OF BIRTH		July 2 <sup>nd</sup>	1915	
		(Month)	(Day)	(Year)
7 AGE		If LESS than 1 day, hrs. OR min.?		
		Yrs.	Mos.	ds.
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)				
Still-Birth				
9 BIRTHPLACE (State or country)				
Md.				
10 NAME OF FATHER				
Wilson Dorsey				
11 BIRTHPLACE OF FATHER (State or country)				
Md.				
12 MAIDEN NAME OF MOTHER				
Cora V. Pollis				
13 BIRTHPLACE OF MOTHER (State or country)				
Md.				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) Louis Jackson				
(Address) Earleigh Hwy 26 1915				
15	Filed July 2, 1915 J.S. Bellinger			
REGISTRAR				
If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.				
Registration Dist. No. 21				
St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]				
16 DATE OF DEATH July 2 <sup>nd</sup> , 1915				
(Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from				
, 191 , to , 191 ,				
that I last saw him alive on , 191 ,				
and that death occurred on the date stated above, at m.				
The CAUSE OF DEATH * was as follows:				
Contributory Secondary				
(Duration) yrs. mos. ds.				
(Signed) James S. Bellinger, M. D.				
July 2, 1915 (Address) Crater, Md.				
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)				
At place of death yrs. mos. ds.				
Where was disease contracted, If not at place of death ?				
Former or usual residence				
In the State, yrs. mos. ds.				
19 PLACE OF BURIAL OR REMOVAL				
Earleigh Heights, Md.				
DATE OF BURIAL July 3, 1915				
20 UNDERTAKER No undertaker				
ADDRESS				

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer at coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE causing DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal sepichiaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED	OCT 6 1915
BUREAU	

## MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH

11081

County *St. J.*

So. Baltimore Sta.,

Village or City Curtis Bay, Md. (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *24*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Donald M. Doyle*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant) *Julia Stahl*(Address) So. Baltimore Sta.,  
Curtis Bay, Md.

15

Filed *July 3<sup>rd</sup>, 1915* Thos. B. Norton

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*July 3<sup>rd</sup>*, 1915 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *June 3<sup>rd</sup>*, 1915, to *July 3<sup>rd</sup>*, 1915, that I last saw him alive on *July 3<sup>rd</sup>*, 1915, and that death occurred on the date stated above, at *3 P.M.*

The CAUSE OF DEATH \* was as follows:

*Bright's Disease*  
*Acute*  
*T.B.*  
(Duration) yrs. mos. ds.Contributory  
Secondary*Thos. B. Norton*  
(Signed) *July 3<sup>rd</sup>, 1915* (Address) So. Baltimore Sta., M. O.State the DISEASE CAUSING DEATH, WHETHER THE DISEASE WAS  
CAUSED BY ACCIDENT, VIOLENT  
CAUSES, STATE (1) MEANS OF INJURY; AND (2) WHETHER ACCIDENTAL,  
SUICIDAL OR HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mss. ds. In the State, yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence19 PLACE OF BURIAL OR REMOVAL  
*Greenmount Cemetery* DATE OF BURIAL  
*July 6<sup>th</sup>, 1915*

20 UNDERTAKER

ADDRESS  
*Jos. B. Cooke*  
*Baltimore, Md.*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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RECEIVED

JULY 5 1918

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

V. S. No. 1.

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**  
**N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See Instructions on back of certificate.**

1 PLACE OF DEATH County	11082 <i>O. J. County</i>
Village or City	Glen Burnie
2 FULL NAME	Bobby Dunn
PERSONAL AND STATISTICAL PARTICULARS	
3 SEX <i>M.</i>	4 COLOR OR RACE <i>W.</i>
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	
6 DATE OF BIRTH <i>July 31</i>	
(Month) (Day), (Year) 1915	
7 AGE <i>2 yrs.</i>	
If LESS than 1 day, hrs. OR min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>None</i>	
(b) General nature of industry business, or establishment in which employed (or employer) <i>None</i>	
9 BIRTHPLACE (State or country) <i>Glen Burnie</i>	
10 NAME OF FATHER <i>Andrew Dunn</i>	
11 BIRTHPLACE OF FATHER (State or country) <i>W.S.</i>	
12 MAIDEN NAME OF MOTHER <i>Gertrude May</i>	
13 BIRTHPLACE OF MOTHER (State or country) <i>H.S.</i>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Andrew Dunn</i>	
(Address) <i>Glen Burnie</i>	
15 Filed <i>Aug 1, 1915</i>	16 Name of Hospital Dept./Locality REGISTRAR <i>Hopkins A. Hospital Dept. Social</i>

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *23*

St.; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <i>July 31</i>	1915 (Month)	1915 (Day)	1915 (Year)
17 I HEREBY CERTIFY, That I attended deceased from <i>July 31, 1915</i> , to <i>July 31, 1915</i> , that I last saw him alive on _____, 1915, and that death occurred on the date stated above, at _____ m.			
The CAUSE OF DEATH * was as follows: <i>Prematurity</i>			
(Duration) yrs. mos. ds.			
Contributory Secondary <i>E. V. Carlisle</i>			
(Duration) yrs. mos. ds. (Signed) <i>E. V. Carlisle</i> , M. D.			
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <i>Mt Carmel Cemetery</i>		DATE OF BURIAL <i>Aug 1, 1915</i>	
20 UNDERTAKER <i>Bob Brooks Son</i>		ADDRESS <i>178 Collier St</i>	

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

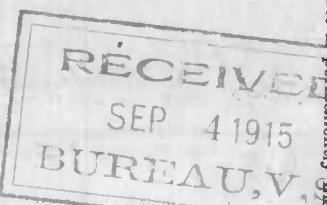
[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the DISEASE causing DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonacum, etc., *Carcinoma*, *Sarcoma*, etc., of: (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anoxia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con-genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

11083

County *Baltimore*Village or City *Sallys*

(No.)

## 2 FULL NAME

*Dortheena Edwards*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)*Infant*

6 DATE OF BIRTH

*May 27, 1913*  
(Month) (Day) (Year)

7 AGE

yrs. 3 mos. 10 ds.

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work*Inferior*(b) General nature of industry  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)*Maryland*10 NAME OF  
FATHER*Oliver Edwards*11 BIRTHPLACE  
OF FATHER  
(State or country)*Maryland*12 MAIDEN NAME  
OF MOTHER*Laura Frankenstein*13 BIRTHPLACE  
OF MOTHER  
(State or country)*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Laura Frankenstein*

(Address)

*Sallys*

15

Filed *July 8, 1913*THOMAS H. DRAKE  
REGISTRARSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *31*

St.; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*July 7, 1913*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
*July 5, 1913*, to *July 7, 1913*,  
 that I last saw her alive on *July 7, 1913*,  
 and that death occurred on the date stated above, at *40* m.  
 The CAUSE OF DEATH \* was as follows:

*Entered Weeks*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) *Thomas H. Drake* (Signature) yrs. mos. da.  
*July 8, 1913* (Address) *Baltimore*

\* State the DISEASE CAUSING DEATH, OR, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place \_\_\_\_\_  
 af death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.  
 Where was disease contracted,  
 if not at place of death?

Former or  
usual residence

In the  
State, \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.

19 PLACE OF BURIAL OR REMOVAL

*Burying ground* (Date) *July 8, 1913*

20 UNDERTAKER

*George Howard* ADDRESS *Sallys*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plasterer*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cook*, *mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmard*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *mени-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal sepihaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 11084  
County Anne Arundel

Village or City Severn (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 22

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Allen Elliott

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) married

6 DATE OF BIRTH

July 26, 1850  
(Month) (Day) (Year)

7 AGE

65 yrs. — mos. — ds.

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

## PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William A. Elliott

(Address) Severn Md

15

Filed July 28<sup>th</sup>, 1915 L. H. E. Haslip

Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 26, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1915, to July 26, 1915, that I last saw him alive on July 26, 1915, and that death occurred on the date stated above, at 6 P.M. The CAUSE OF DEATH \* was as follows:

Dysentery

(Duration) yrs. mos. ds.

Contributory Chronic Diphtheria

Secondary

(Duration) 4 yrs. mos. ds.

(Signed) P. J. Hammond, M.D.

July 27, 1915 (Address) Jessup

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Soldier's Spring Cemetery

20 UNDERTAKER

Fisher & Chair

DATE OF BURIAL

July 28<sup>th</sup>, 1915

ADDRESS

Severn Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer," is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uratnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
AUG 5 1915  
BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

V. S. No. 1.

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**  
**N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See Instructions on back of certificate.**

1985

1 PLACE OF DEATH County	Fairview	3rd Dist	Registration Dist. No. 24
Village or City	16a	SL; Ward)	[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME	Harry Q. Freeman		
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	6 Single
Male	white		
6 DATE OF BIRTH			
(Month) (Day) (Year)			
7 AGE			
24 yrs. mos. ds.			
If LESS than 1 day, hrs. OR min.?			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)			
Chauffeur Gas & Elec. Co Balto			
510 9 BIRTHPLACE (State or country)			
New York			
PARENTS			
10 NAME OF FATHER			
Abraham Freeman			
11 BIRTHPLACE OF FATHER (State or country)			
Russia			
12 MAIDEN NAME OF MOTHER			
Elsie Yakoff			
13 BIRTHPLACE OF MOTHER (State or country)			
Russia			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) Max Chernoff			
(Address) 803 Asquith St			
15 Filed July 23 <sup>rd</sup> , 1915 - Mrs. B. H. Foster M.			
REGISTRAR			
16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place at death yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence			
In the State, yrs. mos. ds.			
17 I HEREBY CERTIFY, that I attended deceased from _____, 191_____, to _____, 191_____, that I last saw h. alive on _____, 191_____, and that death occurred on the date stated above, at 3:30 p.m.			
The CAUSE OF DEATH * was as follows: Accidental Drowning (Duration) yrs. mos. ds.			
Contributory Secondary			
511 (Signature) Harry S. Trower Esq. July 23 <sup>rd</sup> , 1915 (Address) Brooklyn 2nd			
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL			
18 PLACE OF BURIAL OR REMOVAL			
Hebrew Cemetery July 23 <sup>rd</sup> , 1915			
DATE OF BUR.			
20 UNDERTAKER			
S. Levinson Bros. 1104 E. Balto. St. Balto.			

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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ges

, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . .  
(name origin; "Cancer" is less definite; avoid use of  
"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1915

BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

1 PLACE OF DEATH 11086  
 County A. H. County *W.D. C.R.*  
 Village or City Annapolis (No. 13, Gothic Court St.; 4 Ward)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		11086	STATE OF MARYLAND CERTIFICATE OF DEATH	
County A. H. County			Registration Dist. No. 21	
Village or City Annapolis		(No. 13, Gothic Court St.; 4 Ward)	[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME Harriet gross				
PERSONAL AND STATISTICAL PARTICULARS.				
3 SEX Female	4 COLOR OR RACE Colored	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widow		
6 DATE OF BIRTH About 1893		(Month) (Day) (Year)		
7 AGE 62	yrs. — mos. — ds.	If LESS than 1 day, hrs. OR min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work Domestic (b) General nature of industry business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) Annapolis Md				
PARENTS	10 NAME OF FATHER Unknown	Contributory Secondary	Exhaustion	
	11 BIRTHPLACE OF FATHER Maryland	Gradual	(Duration) yrs. mos. de.	
	12 MAIDEN NAME OF MOTHER Isabella Harrod	Down & Dribbles	(Signed) July 13, 1915 (Address) Annapolis Md	
	13 BIRTHPLACE OF MOTHER Annapolis Md	M. O.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Jeannet Bullock (Address) 13 Gothic Court				
15 Filed July 13, 1915	16 DATE OF DEATH July 10th, 1915		(Month) (Day) (Year)	
17 I HEREBY CERTIFY, That I attended deceased from May 15th, 1915, to July 10th, 1915, that I last saw her alive on July 10th, 1915, and that death occurred on the date stated above, at 8 A.M. The CAUSE OF DEATH * was as follows:				
Nephritis Malaria Several months (Duration) yrs. mos. de.				
Contributory Secondary Exhaustion Gradual (Duration) yrs. mos. de. Down & Dribbles (Signed) July 13, 1915 (Address) Annapolis Md				
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. de. In the State, yrs. mos. de. Where disease contracted, if not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL City Cemetery July 13, 1915 DATE OF BURIAL				
20 UNDERTAKER G. F. Adams ADDRESS Annapolis				

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid Fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis* of lungs, *mening-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "*Puerperal septicæma*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County A-A-

11087

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Camp Parole (No.)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Joseph Frederick May Hall

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colord5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Single

## 6 DATE OF BIRTH

Dec. 16, 1914  
(Month) (Day) (Year)

## 7 AGE

7 yrs. 4 mos. 14 ds.If LESS than  
1 day, ..... hrs.  
OR ..... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work...(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Gas

## 9 BIRTHPLACE

(State or country) A-A-Co Md.

## 10 NAME OF FATHER

Joseph Hall.

## 11 BIRTHPLACE OF FATHER

(State or country) A-A-Co Md.

## 12 MAIDEN NAME OF MOTHER

Ella Bettens.

## 13 BIRTHPLACE OF MOTHER

(State or country) A-A-Co Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella B. Hall.(Address) Camp Parole.

## 15

Filed July 16, 1915 - Frank Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

July 16th, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

July 12th, 1915, to July 16th, 1915  
that I last saw him alive on July 12th, 1915and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH\* was as follows:

Gastro Enteritis

(Duration) Yrs. mos. ds.

Contributory  
SecondarySeveral days

Exhaustive

(Duration) Yrs. mos. ds.

(Signed) John G. GradyM.D. July 16th, 1915 (Address) Chambers

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. To the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
It not at place of death?Former or  
usual residence.

## 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Macadonia Cemt. July 17, 1915

## 20 UNDERTAKER

E.H.B. Parker & SonADDRESS 92 West St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Taborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *esisis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 6 1915
BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

11088

County Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 24

Village or City Curtis Bay, (No.) (Benson's Farm)

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Lillian M. Hank

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
female	white	Single

6 DATE OF BIRTH	Month	Day	Year
	March	28 <sup>th</sup>	1915

7 AGE	yrs.	mos.	ds.	If LESS than 1 day.....hrs. OR.....min.?
	3	13		

8 OCCUPATION	(a) Trade, profession, or particular kind of work.
	(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)	Anne Arundel Co.
------------------------------------	------------------

10 NAME OF FATHER	Michael Hank
----------------------	--------------

11 BIRTHPLACE OF FATHER (State or country)	Baltimore Md.
--	---------------

12 MAIDEN NAME OF MOTHER	Hannah Atkinson
-----------------------------	-----------------

13 BIRTHPLACE OF MOTHER (State or country)	Baltimore Md.
--	---------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)	Mr. Hank
---	----------

(Address)	Curtis Creek
-----------	--------------

15	July 11 <sup>th</sup> , 1915	J. B. Horton M.
----	------------------------------	-----------------

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

July 11<sup>th</sup>, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 1<sup>st</sup>, 1915, to July 11<sup>th</sup>, 1915, 4:30 a.m., 2:30 p.m., July 11<sup>th</sup>, 1915, that I last saw her alive on July 11<sup>th</sup>, 1915, and that death occurred on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Acute enterocolitis

Contributory	Malnutrition
Secondary	

(Duration)	yrs. mos. ds.
One	1

(Signed) Geo B Davis, M. D.  
July 11<sup>th</sup>, 1915 (Address) Curtis Bay, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cedars Hill Cemetery	July 11, 1915

20 UNDERTAKER	ADDRESS
J. T. Mc Garry	39 E. Front.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coat lining*, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as *Housewife*, *Housekeeper*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma*,

*Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1915

BUREAU U.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		11089
County	A-A-	
Village or City	St. Margaret (No.)	
2 FULL NAME		
Mary Harris		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX Female	4 COLOR OR RACE Colored	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow
6 DATE OF BIRTH Unknown		
	(Month)	(Day), 18-35 (Year)
7 AGE 80 - yrs	— mos.	— ds. If LESS than 1 day, ____ hrs. OR ____ min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work. Cook.		
(b) General nature of Industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) A-A Co Md.		
PARENTS	10 NAME OF FATHER Thomas Baily	
	11 BIRTHPLACE OF FATHER (State or country) A-A Co Md	
	12 MAIDEN NAME OF MOTHER Rachel Baily	
	13 BIRTHPLACE OF MOTHER (State or country) A-A Co Md	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Charles Harris		
	(Address) St. Margaret Md.	
15	Filed July 16, 1915 - Jms Welch	

6

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

St. Ward

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
July 15, 1915

17 I HEREBY CERTIFY, That I attended deceased from  
May 1908, to July 15, 1915,  
that I last saw her alive on July 8, 1915,  
and that death occurred on the date stated above, at 4:45 p.m.,  
The CAUSE OF DEATH\* was as follows:

Paralytic

(Duration) 7 yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) J. D. Ridout, M. D.

July 16, 1915 (Address) Annapolis, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-  
DENTAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ dsWhere was disease contracted,  
If not at place of death?Former or  
usual residence.19 PLACE OF BURIAL OR REMOVAL  
Broad Neck Crndt. Y. 17, 1915

DATE OF BURIAL

20 UNDERTAKER  
E. H. B. Parker & Son

ADDRESS

92 West St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

E. H. B. Parker &amp; Son 92 West

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonium*, etc., *Carcin-*

oma

"cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mastitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report were symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracinia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 16 1915
BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 11090  
 County *A.A.* 71  
 Village or City *East Brooklyn* (No.)  
 St. \_\_\_\_\_ Ward) 24

2 FULL NAME *Frank Hasse*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single Write the word)
6 DATE OF BIRTH July 1 <sup>st</sup>		(Month) (Day) (Year) July 1, 1915
7 AGE		It LESS than 1 day, 16 hrs. OR min. ?
yrs. — mos. — ds.		

8 OCCUPATION *None*  
 (a) Trade, profession, or particular kind of work.  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE *East Brooklyn*  
 (State or country)

10 NAME OF FATHER *Frank P. Hasse*

11 BIRTHPLACE OF FATHER *Germany*  
 (State or country)

12 MAIDEN NAME OF MOTHER *Annie Carafey*

13 BIRTHPLACE OF MOTHER *Maryland*  
 (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE *Frank P. Hasse*  
 (Informant)

(Address) *East Brooklyn*

15 Filed *July 1<sup>st</sup>, 1915 T.B. Smith, M.D.*

REGISTRAR

STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 24

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 1<sup>st</sup>, 1915*  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY that I attended deceased from *July 1<sup>st</sup>, 1915* to *July 1<sup>st</sup>, 1915*,  
 that I last saw him alive on *July 1<sup>st</sup>, 1915*, and that death occurred on the date stated above, at *12 P.M.*  
 The CAUSE OF DEATH\* was as follows:

*Infantile Convulsions*

(Duration) yrs. mos. 1 hrs.

Contributory Secondary *Frank P. Hasse*

(Duration) yrs. mos. 1 hrs.

(Signed) *W.W. Jackson, M.D.* (Address) *35 Balto. Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL *Holy Cross* DATE OF BURIAL *July 2, 1915*

20 UNDERTAKER *Harle E. & B. Balt. Md.* ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Houswife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Measles," "Convulsions," "Debility" ("Con-senital"), "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1915

BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County A. A. Co.

11091

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 21Village or City Mulberry Hill (No.)

(S)

St. Ward)No NameHenson

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Male Colored

## 6 DATE OF BIRTH

July 29, 1915  
(Month) (Day) (Year)

## 7 AGE

yrs.   mos.   ds.    
If LESS than  
1 day,   hrs.  
OR   min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)A. A. Co. Md

## 10 NAME OF FATHER

Richard Henson11 BIRTHPLACE OF FATHER  
(State or country)A. A. Co. Md

## 12 MAIDEN NAME OF MOTHER

Mary E. Wright13 BIRTHPLACE OF MOTHER  
(State or country)A. A. Co. Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Richard Henson

(Address)

Mulberry Hill, 3d dist A. A. Co.

## 15

Filed July 29, 1915E. M. Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

July 29, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

July 29, 1915 to July 29, 1915  
that I last saw him alive on \_\_\_\_\_, 1915

and that death occurred on the date stated above, at \_\_\_\_\_ m.,

The CAUSE OF DEATH\* was as follows:

Stillbirth

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Lidout, M. D.  
July 29, 1915 (Address) Minneapolis, Minn.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Mulberry Hill farm July 30, 1915

## 20 UNDERTAKER

None

DATE OF BURIAL

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Association.]

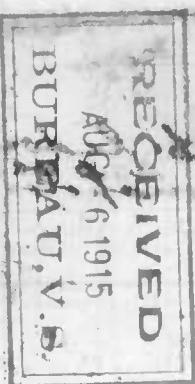
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary engineer*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrotitis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



RECEIVED  
AUG 6 1915  
BURPAU.V.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11092

STATE OF MARYLAND  
CERTIFICATE OF DEATHCounty *Anne Arundel*

Hollins Farm, Second district, near Post Gate

Registration Dist. No. 21

Village or City *Annapolis* (No.)

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *John George Hollins*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 SINGLE, MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word) *Widow*6 DATE OF BIRTH *Unknown*(Month) (Day) (Year) *1*7 AGE *About 94*

yrs.

mos.

ds.

If LESS than  
1 day, hrs.  
OR min.?8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work *Retired Physician*(b) General nature of industry  
business, or establishment in  
which employed (or employer) *Unknown*9 BIRTHPLACE  
(State or country) *England*

## PARENTS

10 NAME OF  
FATHER *Peter Hollins*11 BIRTHPLACE  
OF FATHER  
(State or country) *England*12 MAIDEN NAME  
OF MOTHER *Unknown*13 BIRTHPLACE  
OF MOTHER  
(State or country) *Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *John W. Hollins*(Address) *R. 7 W. t. Annapolis Md*

15

Filed *July 25, 1915* - *Frank Welch*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *about July 20*  
(Month) (Day) (Year) *1915*

17 I HEREBY CERTIFY, That I attended deceased from

, 191 , to , 191 ,

that I last saw h alive on , 191 ,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

*Found dead Probably Myocarditis*(Duration) *Unknown* yrs. moe. ds.Contributory *Arteris sclerosis*Secondary *Unknown*(Signed) *William F. Mannix, Coroner* (Draffon) *July 25, 1915* (Address) *Annapolis, Md.*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State, yrs. mos. ds.

of death Where was disease contracted,  
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *On Farm*DATE OF BURIAL *July 26, 1915*20 UNDERTAKER *John Taylor*ADDRESS *Annapolis, Md.*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Hauswife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *mени-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal sepihaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *scpsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
AUG 6 1915  
BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		11093
County	Anne Arundel	
Village or City	Linthicum Heights (No.)	
2 FULL NAME Andrew Hughes		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
male	Colored	single
6 DATE OF BIRTH		
July 14, 1913		(Month) (Day) (Year)
7 AGE		
yrs. 2	mos. 27	ds. If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION		
(a) Trade, profession, or particular kind of work. None Infant		
(b) General nature of industry, business, or establishment in which employed (or employer) Infant —		
9 BIRTHPLACE (State or country)		
Anne Arundel Co Md		
10 NAME OF FATHER		
George Hughes		
11 BIRTHPLACE OF FATHER (State or country)		
Maryland		
12 MAIDEN NAME OF MOTHER		
Alice Gardner		
13 BIRTHPLACE OF MOTHER (State or country)		
Maryland		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant)		George Hughes Father
(Address)		Linthicum Heights
15	Filed July 13, 1915	
	C. R. H. M. B.	
	REGISTRAR	

104

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 23

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 13, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from June 21, 1915, to July 13, 1915, that I last saw him alive on July 12, 1915, and that death occurred on the date stated above, at 8:53 A.M.

The CAUSE OF DEATH\* was as follows:

Enteric Colitis

22 (Duration) yrs. mos. ds.

Contributory Secondary

Exhaustion

3 (Duration) yrs. mos. ds.  
(Signed) Frank H. Ruhl M. D.  
, 1915. (Address) Pasadena Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL  
McAuburn Cemetery July 14, 1915  
DATE OF BURIAL20 UNDERTAKER  
Chrisl Bounds ADDRESS  
Pasadena Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

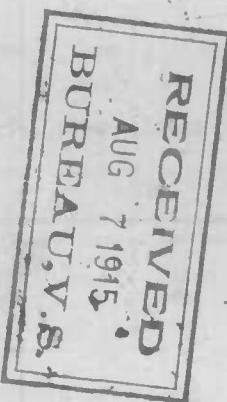
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Tebility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railroad train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sensis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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## MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH 11094  
County A.A.

Village or City Ss Balto. (No. 104)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 24

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John P. Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word) Single

6 DATE OF BIRTH Dec. 30<sup>th</sup>

(Month) (Day) (Year)

7 AGE 6 yrs. 28 mos. 28 ds.

IF LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work

(b) General nature of industry  
business, or establishment in  
which employed (or employer) None

9 BIRTHPLACE  
(State or country) Ss Balto. Md.

10 NAME OF  
FATHER Mrs. John P. Johnson

11 BIRTHPLACE  
OF FATHER (State or country) Norway

12 MAIDEN NAME  
OF MOTHER Mary Hamel

13 BIRTHPLACE  
OF MOTHER (State or country) Ss Balto.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John P. Johnson

(Address) Ss Balto. Md.

15 Filed July 29<sup>th</sup> 1915

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 28<sup>th</sup>

(Month) (Day) (Year) July 28, 1915

17 I HEREBY CERTIFY, That attended deceased from , 1915, to , 1915,

that I last saw h. alive on , 1915,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Enter Colitis

(Duration) yrs. mos. ds.

Contributory  
Secondary

H. P. Johnson  
Burden) yrs. mos. ds.  
Bladder) yrs. mos. ds.  
July 29, 1915 (Address) Ss Balto.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDE or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cathedral Cemetery July 30<sup>th</sup>, 1915

20 UNDERTAKER

J. M. Flynn

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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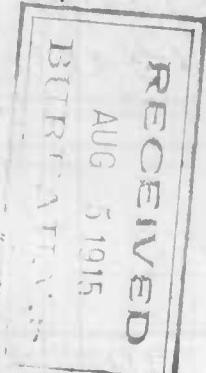
**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges*, *peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1915



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

11095

County Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 23

Village or City Harmons (No.)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME no name

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female	4 COLOR OR RACE colored	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married
--------------	-------------------------	---

6 DATE OF BIRTH

July 14<sup>th</sup>, 1915  
(Month) (Day) (Year)

7 AGE born dead	If LESS than 1 day, hrs. yrs. mos. ds.	OR min. ?
-----------------	--	-----------

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Harmons, Anne Arundel

## PARENTS

## 10 NAME OF FATHER

Charles B. Johnson

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Hora Biggs

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Charles B. Johnson

(Address) Harmons, Anne Arundel

15

Filed 1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 14<sup>th</sup>, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 14, 1915, to July 14, 1915

that I last saw him alive on born dead, 1915

and that death occurred on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Hemorrhage labor necessitated by placenta previa

(Duration) yrs. mos. ds.

Contributory (Secondary) parent

(Duration) yrs. mos. ds.

(Signed) Arthur Williams, M. D.

Aug 15<sup>th</sup>, 1915 (Address) Elkridge, Md.

\* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Farm of Irving Shipley Aug 15, 1915

20 UNDERTAKER no undertaker ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

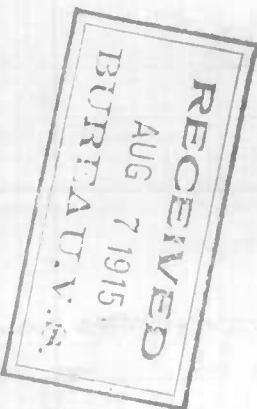
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary engineer*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. It retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.* *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH County..... <i>a.a</i>	11096	STATE OF MARYLAND CERTIFICATE OF DEATH
Village or City..... <i>Jessups</i> (No.)	64	Registration Dist. No. <i>22</i>
2 FULL NAME..... <i>Winston Johnson</i>	St.: _____ Ward: _____	[If death occurred in a hospital or institution, give its NAME instead of street and number.]
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <i>Male</i>	4 COLOR OR RACE <i>colored</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Not known</i> (Write the word)
6 DATE OF BIRTH _____ / _____ / _____ (Month) (Day) (Year)		
7 AGE <i>55</i> yrs. — mos. — ds.	If LESS than 1 day, _____. hrs. OR _____. min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Not known</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>Not known</i>		
9 BIRTHPLACE (State or country) <i>Not known</i>		
10 NAME OF FATHER <i>Not known</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Not known</i>		
12 MAIDEN NAME OF MOTHER <i>Not known</i>		
13 BIRTHPLACE OF MOTHER (State or country) <i>Not known</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (Address) _____		
15 Filed <i>July 13, 1911</i>	L. H. P. Haslup <i>Zoal</i> REGISTRAR	DATE OF BURIAL <i>July 13th, 1911</i>
16 MEDICAL CERTIFICATE OF DEATH 16 DATE OF DEATH <i>July 12, 1911</i> (Month) (Day) (Year)		
17 I HEREBY CERTIFY, That I attended deceased from <i>July 3rd, 1911</i> to <i>July 12, 1911</i> , that I last saw him alive on <i>July 11, 1911</i> , and that death occurred on the date stated above, at _____ m., The CAUSE OF DEATH* was as follows:		
<i>Cerebral Hemorrhage</i>		
(Duration) — yrs. — mos. <i>10 ds.</i>		
Contributory Secondary		
(Duration) — yrs. — mos. — ds.		
(Signed) <i>John Neumayr</i> , M. D. <i>July 12, 1911</i> (Address) <i>Odenton Md.</i>		
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
Where was disease contracted, if not at place of death?		
Former or usual residence _____		
19 PLACE OF BURIAL OR REMOVAL <i>Cherry Tree Bush</i>		
20 UNDERTAKER <i>Fisher &amp; Chain</i>		
ADDRESS <i>Sainte Ma</i>		

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin, "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intervening) affection need not be stated unless important. Examples: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Dolbility" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PURPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railcar train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., scrosis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED	AUG 5 1915	137 R. A. U. S.
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## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

11097

## 1 PLACE OF DEATH

County

a - a -

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

Village or City

St Margreets

(No.)

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Infant Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colo.

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

June 30, 1915  
(Month) (Day) (Year)

7 AGE

1 yrs. 3 mos. 0 ds. If LESS than  
1 day, .... hrs.  
OR min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

St Margreets a-a-co-  
Md.

## PARENTS

## 10 NAME OF FATHER

William Henry Johnson

## 11 BIRTHPLACE OF FATHER

(State or country)

St Margreets Md

## 12 MAIDEN NAME OF MOTHER

Carrie Porter

## 13 BIRTHPLACE OF MOTHER

(State or country)

St Margreets Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant)

W.H. Johnson

(Address)

St Margreets P.O. Md.

15

Filed July 3, 1915

Signed

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 5, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

191... to 191...  
that I last saw him alive on July 3, 1915

and that death occurred on the date stated above, at 2 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia  
7/10

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Joe Dyer, M. D.

July 3, 1915 (Address)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Broad Neck Cemt. DATE OF BURIAL  
7. 3. 1915

20 UNDERTAKER E.H. Parker &amp; Son

ADDRESS  
92 West St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laboree*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma

"cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Muras mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 6 1915

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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11098

1 PLACE OF DEATH County <i>Anne Arundel</i>		STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <i>Oxonville State Hospital</i>		Registration Dist. No. <i>21</i>		
2 FULL NAME <i>John Leonard</i>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <i>Male</i>	4 COLOR OR RACE <i>Red</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Married</i>	MARINE	
6 DATE OF BIRTH <i>Unknown</i>		(Month) (Day) (Year)		
7 AGE <i>Unknown</i>	YRS. <i>0</i>	MOS. <i>0</i>	ds. <i>0</i>	If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Unknown</i> (b) General nature of industry business, or establishment in which employed (or employer) <i>Unknown</i>				Chronic Intestinal Nephritis unknown Contributory Pulmonary Tuberculosis
9 BIRTHPLACE (State or country) <i>Maryland</i>				Duration yrs. <i>10</i> mos. <i>0</i> de.
10 NAME OF FATHER <i>Unknown Leonard</i>				(Signed) <i>Robert D. Montrose</i> (Address) <i>Oxonville Md.</i>
11 BIRTHPLACE OF FATHER (State or country) <i>Md</i>				State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
12 MAIDEN NAME OF MOTHER <i>Unknown</i>				13 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place <input checked="" type="checkbox"/> yr. <input checked="" type="checkbox"/> mes. <input checked="" type="checkbox"/> ds. of death <input checked="" type="checkbox"/> yr. <input checked="" type="checkbox"/> mes. <input checked="" type="checkbox"/> ds. Where was disease contracted, if not at place of death?
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Hospital</i>				In the <input checked="" type="checkbox"/> yr. <input checked="" type="checkbox"/> mos. <input checked="" type="checkbox"/> ds. State, <i>Unknown</i>
(Address) <i>Records</i>				Former or usual residence <i>Dorchester County</i>
15 Filed <i>July 31, 1915</i>		16 PLACE OF BURIAL OR REMOVAL <i>Gambidge Md</i>		DATE OF BURIAL <i>July 31, 1915</i>
17 UNDERTAKER <i>Spig Welch</i>		20 ADDRESS <i>J. Adams Annapolis</i>		

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housemaid*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 6 1915

BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH

11099

County

Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

25

Village or City

Brooklyn

(No.)

Lark St. Extended

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Alice Kindt

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

16 DATE OF DEATH

July

13<sup>th</sup>

(Month)

(Day)

(Year)

6 DATE OF BIRTH

Sept

(Month)

18 27

(Day)

1906

7 AGE

8

yrs.

9

mos.

27

ds.

If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Germany

## PARENTS

10 NAME OF  
FATHER

Herman Kindt

11 BIRTHPLACE  
OF FATHER

(State or country)

Germany

12 MAIDEN NAME  
OF MOTHER

Almae Allemann

13 BIRTHPLACE  
OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herman Kindt (Father)

15

Filed

July 16, 1915 Chas. St. Brook

REGISTRAR

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

13<sup>th</sup>

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from July 13<sup>th</sup>, 1915, to July 13<sup>th</sup>, 1915, that I last saw her alive on July 13<sup>th</sup>, 1915, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH \* was as follows:

Acute indigestion

(Duration) — yrs. — mos. 5 1/4

Contributory  
Secondary

Convulsions

(Duration) — yrs. — mos. 4 1/2

(Signed)

Harry Heber

M. D.

July 14<sup>th</sup>, 1915 (Address) 125 Saratoga St., Balto.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cedar Hill

DATE OF BURIAL

July 16, 1915

20 UNDERTAKER

Armstrong &amp; Denby Co

ADDRESS

715 Light St.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmard*, etc. If the occupation has been changed or given up on account of the disease causing death, state ~~the~~ <sup>the</sup> occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonitis*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reactor wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BURIAL U.V.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH 11100  
 County Anne Arundel  
 Village or City Robinsons (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Isaac Kirby

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE white	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) wedmed
6 DATE OF BIRTH Oct		14, 1835 (Month) (Day) (Year)
7 AGE 79 yrs. 9 mos. ds.	It LESS than 1 day, hrs. OR min. ?	

50 25  
 8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Pilot  
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF FATHER Don't know Kirby

11 BIRTHPLACE OF FATHER  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Nedmed H. Arundel

13 BIRTHPLACE OF MOTHER  
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Nedice See Walton

(Address) 2187 Broadway A.C.

15 Filed July 13, 1915 Thomas H. Brugh  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 13, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1915, to July 13, 1915, that I last saw him alive on July 13, 1915, and that death occurred on the date stated above, at 12 P.M. The CAUSE OF DEATH \* was as follows:

Over fatal heart trouble

(Duration) yrs. mos. days

Contributory  
Secondary

(Signed) Thomas H. Brugh M.D.  
July 13, 1915 (Address) 2187 Broadway

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_  
at death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL London Park

20 UNDERTAKER Elbert Fuller

DATE OF BURIAL July 14, 1915

ADDRESS 2 Broadway St.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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AUG 6 1915

BUREAU,



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*oma, Sarcoma*, etc. of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Triaemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal* *ptomaine*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1915

BUREAU U.S.A.

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County a. a.

Village or City Sd Balto. Md2 FULL NAME Mary Lukes

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)6 DATE OF BIRTH July 11<sup>a</sup>

(Month) (Day) (Year)

7 AGE

yrs. mds. ds.

It LESS than  
1 day 2 hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed July 12<sup>b</sup>, 1915 T. B. Heron MD

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 34St. Ward)[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 11<sup>a</sup>(Month) July (Day) 11 (Year) 191517 I HEREBY CERTIFY, That I attended deceased from July 11<sup>a</sup>, 1915, to July 11<sup>b</sup>, 1915, that I last saw her alive on July 11<sup>b</sup>, 1915, and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH \* was as follows:

Infantile convulsions(Duration) 2 hrs.

## Contributory

Secondary

Thomas B. Heron  
(Signed) July 12<sup>b</sup>, 1915 (Address) Sd Balto. Md (Burial) W. m. o.\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place In the  
of death State, yrs. mds. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence19 PLACE OF BURIAL OR REMOVAL Oak Hill Cemetery DATE OF BURIAL July 12<sup>b</sup>, 191520 UNDERTAKER Frank Crampton Balto ADDRESS 16 W. Saratoga St., Balto.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

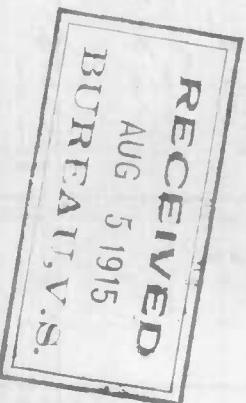
[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonitacum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name, origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Conia," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		11103
County		Anne Arundel
Village or City		Gambries (No.)
2 FULL NAME		
John C. McCleary		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	white -	Single
6 DATE OF BIRTH		
Unknown, 1		
(Month) (Day) (Year)		
7 AGE	If LESS than 1 day, .... hrs. OR min. ?	
24 yrs. — mos. — ds.		
8 OCCUPATION		
(a) Trade, profession, or particular kind of work		
Iron Laborer		
(b) General nature of industry, business, or establishment in which employed (or employer)		
Government Dairy Farm		
9 BIRTHPLACE (State or country)		
Scotland		
10 NAME OF FATHER		
Unknown		
11 BIRTHPLACE OF FATHER (State or country)		
Scotland		
12 MAIDEN NAME OF MOTHER		
Unknown		
13 BIRTHPLACE OF MOTHER (State or country)		
Scotland		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant) _____		
(Address) _____		
15 Filed 9/6, 1915 by Local Registrar		

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

186

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 6, 1915

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

accident due to explosion of gun powder while at work grinding powder

(Duration) yrs. mos. ds.

Contributory  
Secondary(Signed) E. D. Joyce Justice the Peace, M. D.  
acting as Coroner for State & Maryland  
7/6, 1915 (Address) Miller's Corner Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death yrs. mos. ds. State yrs. mos. ds.Where was disease contracted,  
if not at place of death? \_\_\_\_\_Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Baldwin Mem. Cemetery DATE OF BURIAL 7/8, 1915

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

R. J. Williams Son Waterbury Md-

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RECEIVED

AUG 6 1915

BUREAU, U.S.

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH		11104
County		<i>A. A. Co.</i>
Village or City		<i>Maryland</i> (No.)
<sup>2</sup> FULL NAME		
<i>Benj' F. M<sup>c</sup>Gahre</i>		
PERSONAL AND STATISTICAL PARTICULARS		
<sup>3</sup> SEX	<sup>4</sup> COLOR OR RACE	<sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<i>Male</i>	<i>White</i>	<i>Married</i>
<sup>6</sup> DATE OF BIRTH		
<i>Nov 4<sup>th</sup></i> (Month) <i>1870</i> (Year)		
<sup>7</sup> AGE	<i>45 yrs. 8 mos. 4 ds.</i>	If LESS than 1 day.....hrs. OR min.?
<sup>8</sup> OCCUPATION		
(a) Trade, profession, or particular kind of work.		
<i>Merchant</i>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
<i>General merchandise</i>		
<sup>9</sup> BIRTHPLACE		
(State or country)		
<i>Madison N. J.</i>		
<sup>10</sup> NAME OF FATHER	<i>H. M<sup>c</sup>Gahre</i>	
<sup>11</sup> BIRTHPLACE OF FATHER	(State or country)	
<i>Va</i>		
<sup>12</sup> MAIDEN NAME OF MOTHER	<i>Mary Webster</i>	
<sup>13</sup> BIRTHPLACE OF MOTHER	(State or country)	
<i>North Carolina</i>		
<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant)		
<i>Mrs Benj' F M<sup>c</sup>Gahre</i>		
(Address)		
<i>Post Laurel Md.</i>		
<sup>15</sup>	Filed	<i>July 12, 1915</i>
	L	<i>H P Hodges</i>
	Local	<i>REGISTRAR</i>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

155

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 22

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St. Ward

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH *July 9<sup>th</sup>* (Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from 191... to 191...

that I last saw h. alive on 191...

and that death occurred on the date stated above, at about 3:30 A.M.

The CAUSE OF DEATH was as follows:

*Suicide by Hanging  
brought on by nervous break  
down*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) *James A. Struark* (Address) *Patuxent Hall*

July 9<sup>th</sup>, 1915 (Address) *Patuxent Hall*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

<sup>19</sup> PLACE OF BURIAL OR REMOVAL *Laurel Bank* DATE OF BURIAL *July 12th, 1915*

<sup>20</sup> UNDERTAKER *Fisher & Chain* ADDRESS *Laurel Md.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laboree*, *Farm laboree*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anethenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 5 1915

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
A.A. 11105

County.....

Village or City Brooklyn No.....

2 FULL NAME Mrs. Nellie F. Mc Lynn

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.	4 COLOR OR RACE W.	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) m.
----------	--------------------	--

6 DATE OF BIRTH Feb. 6, 1866  
(Month) (Day) (Year)

7 AGE 49 yrs. 5 mos. 3 ds.  
If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work Housewife  
(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country) Md.

10 NAME OF  
FATHER Chas. Dames

11 BIRTHPLACE  
OF FATHER  
(State or country) Md.

12 MAIDEN NAME  
OF MOTHER Elizabeth Ness

13 BIRTHPLACE  
OF MOTHER  
(State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) My. Mc Lynn

(Address) Brooklyn, Md.

15 FILED 7/10, 1915 J. B. Norton

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 24

St. Ward

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 9, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from June 15, 1915, to July 9, 1915,  
that I last saw her alive on July 9, 1915,  
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH \* was as follows:

Chronic Parenchymatous  
Nephritis (Duration) 1 yrs. 6 mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
(Signed) 7/8/05 (Address) 1075 West St., M. B.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
In the State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL Holy Cross DATE OF BURIAL  
7/12, 1915

20 UNDERTAKER J. & M. Flynn ADDRESS  
1422 Light

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthiness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*; *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *latencies*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV - 6 1915

RECEIVED  
AUG 5 1915

BUREAU, N.Y.

Sent out to be signed on this form.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County		11106
Village or City		So. Balto. (No.)
2 FULL NAME Viola Miller		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
6 DATE OF BIRTH May 23 <sup>rd</sup>	(Month) (Day)	(Year) 1901
7 AGE 14 yrs. 3 mos. 15 ds.	If LESS than 1 day, ____ hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work Home		
8 BIRTHPLACE (State or country) Balto. Md		
PARENTS	10 NAME OF FATHER S. J. Miller	11 BIRTHPLACE OF FATHER (State or country) Balto. Md
	12 MAIDEN NAME OF MOTHER Ella Weitzel	13 BIRTHPLACE OF MOTHER (State or country) Balto. Md
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) S. J. Miller (Address) 1815 Light St. Balto. Md		
15 Filed July 11 <sup>th</sup> , 1915	Thos. D. Cotton M.D.	
REGISTRAR		

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 24

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
July 11<sup>th</sup>

(Month) (Day) (Year), 1915

17 I HEREBY CERTIFY, THAT I attended deceased from

that I last saw h. alive on 191 to 191

and that death occurred on the date stated above, at 3 p.m.

The CAUSE OF DEATH\* was as follows:

Accidental  
Drowning

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) James H. Bowley, M.D.  
July 11<sup>th</sup>, 1915 (Address) Brooklyn, N.Y.\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIEN-  
TAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL  
St. Carmel Cemetery July 14<sup>th</sup>, 1915

DATE OF BURIAL

ADDRESS

20 UNDERTAKER  
E. Schlossman

Balto. Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employees, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. Examples:

(a) *Shinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer-Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Epidemic cerebrospinal meningitis*; *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified—is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**RECEIVED**

AUG 5 1915

BUREAU, U. S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH County.....		11107 <i>Anne Arundel</i>	
Village or City.....		<i>Bonnes</i> (No.)	
2 FULL NAME.....		<i>Mary E Ann Moran</i>	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Married</i> (Write the word)	
6 DATE OF BIRTH <i>May 20 1869</i>		If LESS than 1 day, hrs. OR min. ?	
7 AGE <i>46</i>	Yrs. <i>1</i>	mes. <i>17</i>	ds. <i>11</i>
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Housewife</i> (b) General nature of Industry business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <i>Al Co - Ma.</i>			
10 NAME OF FATHER <i>Thos Oster Bell</i>			
11 BIRTHPLACE OF FATHER (State or country) <i>Maryland -</i>			
12 MAIDEN NAME OF MOTHER <i>Mary E Craig</i>			
13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Anna Rebecca Bell</i> (Address) <i>Langdon St C</i>			
15 Filed <i>July 8, 1915</i>		REGISTRAR	

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *21*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
*July 7th*, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
191..., to 191...,

that I last saw him alive on , 191...,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

*Cerebral hemorrhage*  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) *Thomas A. Douglass, M. D.*  
July 8, 1915 (Address) *Elm Avenue*  
(Duration) yrs. mos. ds.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted,  
If not at place of death ?  
Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL <i>Piney Grove</i>	DATE OF BURIAL <i>July 9th, 1915</i>
20 UNDERTAKER <i>John J. Dalton</i>	ADDRESS <i>Elm Avenue</i>

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cold mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *All school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Labor pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonitis*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-mus," "Old Age," "Shock," "Uratinita," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmias," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *ulcerus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11108

County *a a*STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *21*Village or City *Annapolis*(No. *2*)*O'Brien's Alley*, St. *4* Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Sarah Murdoch*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
<i>Female</i>	<i>Colored</i>	<i>Widowed</i>

6 DATE OF BIRTH

*June 30, 1850*  
(Month) (Day) (Year)

7 AGE

*65 yrs.* *9 mos.* *2 ds.*  
If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work *House Wife*
- (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)*Baltimore and*

## PARENTS

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER

(State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER

(State or country)

*Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mary Murdoch*(Address) *2 O'Brien's Alley*

15

Filed *July 9, 1915* — *Frank Welch*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*July 7th, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *May 18th, 1915* to *July 7th, 1915*,  
that I last saw her alive on *July 7th, 1915*,  
and that death occurred on the date stated above, at *7:00 p.m.*

The CAUSE OF DEATH \* was as follows:

*Mithal Stenosis  
Cardiac Diphtheria  
Several months  
Gastric haemorrhage  
Duration yrs. mos. ds.  
(Signed) John Ridout M. D.  
July 7th, 1915 (Address)*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted,  
if not all place of death?

Former or  
usual residence

In the  
State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

19 PLACE OF BURIAL OR REMOVAL

*Bacon Hill*

20 UNDERTAKER

*B. J. Coffing*

DATE OF BURIAL

*7/9, 1915*

ADDRESS

*Annapolis*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary engineer*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housenaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name) origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosquitos*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 6 1915

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

V. S. No. 1.  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11109

County *A.A.*STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

Village or City *Annapolis*

(No.)

*Hale Circle*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Annie J. Nelson*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
<i>Female</i>	<i>White</i>	<i>MARRIED</i>

6 DATE OF BIRTH

*Oct 25, 1845*  
(Month) (Day) (Year)

7 AGE

*69 yrs. 8 mos. 9 ds.*  
If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work *House wife*
- (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)*Mass.*

10 NAME OF FATHER

*Emerson Ames*11 BIRTHPLACE OF FATHER  
(State or country)*Maine*

12 MAIDEN NAME OF MOTHER

*Annie J. Gregory*13 BIRTHPLACE OF MOTHER  
(State or country)*Maine*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Capt. J. Nelson U.S.N.*

(Address)

*Annapolis Md.*

15

Filed *July 6, 1915* *J. J. Welch*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*July 4, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *July 4<sup>th</sup>, 1915*, to *July 4<sup>th</sup>, 1915*, that I last saw her alive on *July 4<sup>th</sup>, 1915*, and that death occurred on the date stated above, at *5:20 p.m.*

The CAUSE OF DEATH \* was as follows:

*Acute Cardiac  
Dilatation* (Duration) *10 yrs. 6 mos. 10 days.*

Contributory  
Secondary

*Diabetes Melitus* (Duration) *10 yrs. 6 mos. 10 days.*

(Signed)

*S. S. Hepburn* M. O.

*July 5, 1915* (Address) *Annapolis Md.*  
\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL OR HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place  
of death *yrs. mos. ds.* In the  
Where was disease contracted,  
if not at place of death? State, *yrs. mos. ds.*

Farmer or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

*Baltimore Md.* DATE OF BURIAL  
*July 7, 1915*

20 UNDERTAKER

*Jas. S. Taylor, Son* ADDRESS  
*Annapolis Md.*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Collon mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menn-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 6 1915
BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County *a a*

11110

MP

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *21*Village or City *Annapolis*(No. *139*, West St)St. *3* Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

*Beatrice A Parker*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Colored

5 SINGLE,  
MARRIED,  
WIDWED  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

July 22, 1918  
(Month) (Day) (Year)

7 AGE

1 yrs. 6 mos. 12 ds.

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

*Camp Groce Md*

## PARENTS

10 NAME OF FATHER

*Addison Parker*

11 BIRTHPLACE OF FATHER

(State or country)

*South River Md*

12 MAIDEN NAME OF MOTHER

*Matilda Johnson*

13 BIRTHPLACE OF MOTHER

(State or country)

*A. A. Co Md*

14 THE ABDVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Beatrice Addison*(Address) *39 Cathedral St*

15

Filed *July 6, 1918* by *Tom Welch*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 4, 1918  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 4, 1918, to July 4, 1918, that I last saw her alive on July 4, 1918, and that death occurred on the date stated above, at *7:30 A.M.*

The CAUSE OF DEATH was as follows:

*Cerebro-spinal meningitis,  
Tuberculosis (Duration) yrs. mos. yrs.  
Contributory Secondary Exhauation*(Duration) yrs. mos. ds.  
(Signed) *Harold T. Howard* M. D.  
July 6, 1918 (Address) *80 Franklin St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CASES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

In the State, yrs. mos. ds.

19 PLACE OF BURIAL OR REMOVAL

*Danvers Chapel*

DATE OF BURIAL

*July 6, 1918*

20 UNDERTAKER

*B. J. Hoppe*

ADDRESS

*Annapolis Md*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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RECEIVED

AUG 6 1915

BUREAU, U.S.



# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

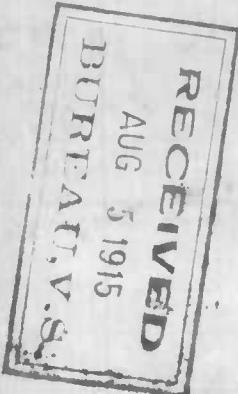
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (o) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urtaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**  
**N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See instructions on back of certificate.**

1 PLACE OF DEATH

11112

County *St. Louis*STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 24

Village or City *So Balto.* (No. 25, Cedar)

St.; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]2 FULL NAME *Vera Pasalac*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>W</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Single</i> (Write the word)
6 DATE OF BIRTH <i>Feb 18</i> (Month) (Day) (Year)		
7 AGE <i>5 yrs. 9 mos. 9 ds.</i> If LESS than 1 day, hrs. OR min.?		

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work.  
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
 (State or country) *Curtis Bay*

10 NAME OF FATHER *Doris Pasalac*

11 BIRTHPLACE OF FATHER (State or country) *Russia*

12 MAIDEN NAME OF MOTHER *Odette Kroes*

13 BIRTHPLACE OF MOTHER (State or country) *Russia*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) *Doris Pasalac*

(Address) *25 Cedar St*15 Filed *July 27, 1915* by *Dr. B. Norton*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 27, 1915*

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *July 27, 1915*, to *July 27, 1915*,  
 that I last saw her alive on *July 27, 1915*, and that death occurred on the date stated above, at *1 p.m.*

The CAUSE OF DEATH \* was as follows:

*Infantile Convulsions**Indigestion* (Duration) *1 hr. 3 hrs.**Dr. B. Norton* (Duration) *1 hr. m. sec.**July 27, 1915* (Address) *So Balto Md.* M. O.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, CRIMES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *yr. mo. da.* In the State, *yr. mo. da.*

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL *July 27, 1915*UNDERTAKER *Holy Cross*ADDRESS *John Giblinas, 500 S Pacific*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer employed*, as *At school* or *At home*. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges

ges, *peritonitis*, etc, *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility," ("Con genitalia," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 5 1915

BUREAU U.S.A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Anne Arundel 11113

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 26

Village or City Seale (No.) D

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME Benjamin Franklin Phipps

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	single

## 6 DATE OF BIRTH

Feb 10, 1914  
(Month) (Day) (Year)

## 7 AGE

1 yrs. 5 mos. 18 ds.

If LESS than  
1 day. hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work none  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Maryland

## PARENTS

10 NAME OF FATHER Benjamin F. Phipps  
11 BIRTHPLACE OF FATHER Maryland  
12 MAIDEN NAME OF MOTHER Ruby M. Rodgers  
13 BIRTHPLACE OF MOTHER Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. J. Rodgers

## 15

(Address) Seale, Md  
Filed July 29, 1915 - Ges T. Seal, M.D.  
Sep. Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

July 28, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1915, to July 27, 1915, that I last saw him alive on July 27, 1915, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH \* was as follows:

Typhoid fever

(Duration) — yrs. — mos. 29. ds.

Contributory  
Secondary

(Duration) — yrs. — mos. de.

(Signed) Ges T. Seal, M.D.  
July 29, 1915 (Address) Princeton, Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CASES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. de. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Rodgers Cemetery on Seale

DATE OF BURIAL

July 29, 1915

## 20 UNDERTAKER

Hardenby &amp; Hank

ADDRESS

Galloways

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Pionter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Term laborer*, *Laborer* — *Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia* ("Pneumonia"; *Bronchopneumonia*, unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County A.A.C.

11114

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Eastport(No. 291 Third)St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Still Infant Pindell.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE colored5 SINGLE,  
MARRIED,  
WIDOWED,  
DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

July 19, 1915  
(Month) (Day) (Year)

7 AGE

unborn  
yrs. — mos. — ds.  
If LESS than  
1 day, ..... hrs.  
OR ..... min. ?

## 8 OCCUPATION

- (a) Trade, profession, or  
particular kind of work.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

UnknownUnknown9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHERA.A.Co. md.  
Robert Pindell11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Birdie Turner Pindell291 Third St

15

Filed July 20, 1915By J.W. Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 19, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
on July 19, 1915, to —, 1915,that I last saw him alive on —, 1915,and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH\* was as follows:

Still birth

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Ambrose Garcia M. D.  
July 20, 1915 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the  
of death yrs. mos. ds. State yrs. mos. ds.Where was disease contracted,  
If not at place of death?Former or  
usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Brewer Hill Cemetery July 21, 1915

DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS

E.H.B. Parker & Son 92 West St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Garcia

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Nature, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Epidemic cerebrospinal meningitis*; *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosches*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Murasinus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrotis, telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 6 1915
BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11115

County Anne Arundel Co.Village or City Annapolis Md (No. 8) Carroll St.; 3 Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Pauline Pointer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

May 28<sup>th</sup>, 1914  
(Month) (Day) (Year)

7 AGE

1 yrs. 1 mos. 8 ds. If LESS than  
1 day, \_\_\_\_ hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Annapolis, Md

## PARENTS

10 NAME OF FATHER

William Pointer

11 BIRTHPLACE OF FATHER

(State or country)

Annapolis, Md

12 MAIDEN NAME OF MOTHER

Molda Carroll

13 BIRTHPLACE OF MOTHER

(State or country)

Annapolis, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Molda Pointer(Address) 8 Carroll St.

15

Filed July 6, 1915 by J. M. G. Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 6, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from

July 2, 1915, to July 5, 1915

that I last saw him alive on July 5, 1915

and that death occurred on the date stated above, at 1 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebro-spinal meningitis,  
tuberculosis (Duration) yrs. mos. ds.Contributory  
Secondary

Ex-husband

(Duration) yrs. mos. ds.

(Signed) Harold W. Townsend, M.D.July 6, 1915 (Address) 80 Franklin St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Mt.abor July 7<sup>th</sup>, 1915 (Date of Burial)

20 UNDERTAKER

Samuel Allen ADDRESS 32. N.W. St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

[Approved by U. S. Census and American Public Health Association.]

## CERTIFICATE OF DEATH

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Hauswife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonymy is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JULY 11 1915

REF. ATT. V. 8

## MARGIN RESERVED FOR BINDING

V. S. No. 1.  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

11116

## 1 PLACE OF DEATH

County Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

Village or City

Crownsville State Hospital

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Henry Proctor

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCEDMarried  
(Write the word)

6 DATE OF BIRTH

Unknown, 1847  
(Month) (Day) (Year)

7 AGE

68 Unknown yrs. mos. ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

Farmer

9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

10 NAME OF FATHER

Charles Proctor

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mathilda ?

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital

(Address)

Records

15

Filed 7/21, 1915

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 20, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1915, to July 20, 1915, that I last saw him alive on July 20, 1915, and that death occurred on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH \* was as follows:

Chronic valvular heart disease

Contributory Broken Compensation  
Secondary Duration yrs. mos. ds.

Duration yrs. mos. ds.

(Signed) Robert W. Minterod, M. D.  
July 22, 1915 (Address) Crownsville, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place  
af death yrs. mos. da. In Ida.  
Where was disease contracted,  
if not at place of death?Former or  
usual residence Prince Georges County

19 PLACE OF BURIAL OR REMOVAL

Hospital Cemetery

DATE OF BURIAL

7/23, 1915

20 UNDERTAKER

R. W. Minterod, Esq.

ADDRESS

Wauwyn, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"; unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

11117

County *a.a*Village or City *Spa Road* (No.)STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Lorenzo Pulley Lorenzo*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

*Sept 15, 1850*  
(Month) (Day) (Year)

7 AGE

*44 yrs. 9 mos. 20 ds.*If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work  
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed *July 8, 1915*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*July 5, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *June 1<sup>st</sup>, 1915*, to *July 1<sup>st</sup>, 1915*, that I last saw him alive on *July 1<sup>st</sup>, 1915*, and that death occurred on the date stated above, at *7 A.M.*. The CAUSE OF DEATH \* was as follows:

*Cardiac dilatation* (Duration) yrs. mos. ds.*Contributory Chronic nephritis &*  
Secondary*Endocarditis* (Duration) 1 yrs. mos. ds.(Signed) *S. S. Hepburn* M. D.*July 8, 1915* (Address) *Annapolis, Md.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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RECEIVED

AUG 6 1915

BUREAU U.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH

11118

County

Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 23

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Glen Burnie (No.)

2 FULL NAME

Mattie S. Pumphrey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Sept 10, 1877  
(Month) (Day) (Year)

7 AGE

37 yrs. 9 mos. 24 ds.  
If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE

(State or country)

Brooklyn At C.M.D.

PARENTS

10 NAME OF FATHER

C. Jordan

11 BIRTHPLACE OF FATHER

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Katie Greenstreet

13 BIRTHPLACE OF MOTHER

(State or country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma Parker (Sister)

(Address)

Stone House Cov. Accs.

15

Filed July 7, 1915

Thomas H. Brasher

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 4, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 3rd 1915, to July 4th 1915, that I last saw her alive on July 4th 1915,

and that death occurred on the date stated above, at 3 m.

The CAUSE OF DEATH\* was as follows:

Septic - peritonitis  
Following abortion  
Duration 30 days  
yrs. mos. 14 ds.Contributory  
Secondary

Same

(Duration) yrs. mos. 14 ds.

(Signed) Arthur Williams M. D.  
July 5, 1915 (Address) Elk Ridge, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Pumphrey Burial Ground July 7, 1915

20 UNDERTAKER

ADDRESS

Armstrong-Denny Ballard

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 7 1915

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

**N. B.—** Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

11119

County Anne Arundel

Village or City Rhode River (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 20

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Stillborn child of Herman Leard

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single
6 DATE OF BIRTH July 12, 1915		(Monthly) (Day) (Year)
7 AGE 0 yrs. 0 mos. 0 ds.		If LESS than 1 day hrs. OR min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Herman Augustus Leard

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Estell Leard

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice Estell Leard

(Address) South River Md.

15 Filed July 12, 1915 John Collinson Sub. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 12, 1912  
 Month (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1912, to \_\_\_\_\_, 1912, that I last saw him alive on \_\_\_\_\_, 1912, and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Prolapse of the umbilical cord. Hemorrhage present at birth.

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) John Collinson, M. D.  
 (Address) South River Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hoppe Chapel July 13, 1915

20 UNDERTAKER George Stalling ADDRESS

No undertaker Mayo Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "*Laborer*," "*Foreman*," "*Manager*," "*Dealer*," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "*Cancer*" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthma*," "*Anæmia*" (merely symptomatic), "*Atrophy*," "*Col-lapse*," "*Coma*," "*Convulsions*," "*Dobility*" ("Con-genital," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Hemorrhage*," "*Inanition*," "*Mara-mus*," "*Old Age*," "*Shock*," "*Uremia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "*Contributory*." (Recommendations on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

11120

County

Village or City

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 24

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Unknown, 1865  
(Month) (Day) (Year)

7 AGE

50 yrs. X mos. X ds.

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

July 2<sup>nd</sup>, 1915

J.B. Keeler, Md.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 1<sup>st</sup>, 1915  
(Month) (Day) (Year)

17

I HEREBY CERTIFY That I attended deceased from

, 191..., to , 191...  
that I last saw h alive on , 191...

and that death occurred on the date stated above, at , 191...

The CAUSE OF DEATH\* was as follows:

Concussion of Brain  
Fell from scaffold  
while at work

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) James H. Farley, M.D.  
July 2<sup>nd</sup>, 1915 (Address) Berwyn, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Mr. Jean (Date of Burial) July 4, 1915

20 UNDERTAKER

Clarence C. Wright (Address) 1364 N. Carey

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1915

BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County *A. A.*

11121

Village or City *So. Balto.* (No. *64*)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

2 FULL NAME *George Melvin Reddish*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
<i>Male</i>	<i>White</i>	<i>MARRIED</i>

6 DATE OF BIRTH *March 10, 1892*  
(Month) (Day) (Year)

7 AGE *63 4 3*  
yrs. mos. ds. If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work  
*Laborer*  
(b) General nature of industry  
business, or establishment in  
which employed (or employer)  
*Standard Fertilizer*

9 BIRTHPLACE  
(State or country) *A. A. C.*

10 NAME OF  
FATHER *Turnee J. Reddish*

11 BIRTHPLACE  
OF FATHER  
(State or country) *Maryland*

12 MAIDEN NAME  
OF MOTHER *Ellen Burnette*

13 BIRTHPLACE  
OF MOTHER  
(State or country) *Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Turnee J. Reddish*

(Address) *So. Balto. Md.*

15 Filed *July 15, 1915* T. B. Horton, M.D., Reg. No. *107*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 13, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
191 to 191, that I last saw him alive on

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

*Apopathy*  
(Duration) yrs. mos. ds.

Contributory  
Secondary

*James T. Fowler, Esq.*  
(Signature) *July 13, 1915* (Address) *Brooklyn*  
(Duration) yrs. mos. ds.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Cedar Tree Cemetery* DATE OF BURIAL *July 16, 1915*

20 UNDERTAKER *M. Holt T. Turner* ADDRESS *So. Balto.*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired yes.)*. For persons who have no occupation whatever, state *None*.

**Statement of Cause of Death**—Name, first, the disease using death (the primary affection with respect to life and causation), using always the same accepted name for the same disease. Examples: *Cerebrospinal meningitis*"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Pneumonia*, *Bronchopneumonia* ("Pneumonia," qualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonium*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 d.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Coughing," "Coma," "Convulsions," "Debility," ("Concussion," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OR AS PROBABLY SUCH, IF IMPOSSIBLE TO DETERMINE DEFINITELY. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1915

BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11122

County A.A.STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Eastport (No. 712)St. Ward)[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

2 FULL NAME

John Compton Riley

## PERSONAL AND STATISTICAL PARTICULARS

<u>3 SEX</u>	<u>4 COLOR OR RACE</u>	<u>5 SINGLE, MARRIED, WIDOWED OR DIVORCED</u> (Write the word)
<u>Male</u>	<u>White</u>	<u>Single</u>

6 DATE OF BIRTH

Sept 17, 1914

7 AGE

9 yrs. 23 mos. 23 ds.If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)None

9 BIRTHPLACE

(State or country)

Eastport A.A.C. Md.

PARENTS

10 NAME OF FATHER John Riley11 BIRTHPLACE OF FATHER Annapolis Md12 MAIDEN NAME OF MOTHER Ruth Moreland13 BIRTHPLACE OF MOTHER A. A. Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Riley(Address) Eastport A.A.C. Md.15 Filed July 11, 1915 - J. M. Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 10<sup>th</sup> 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 7<sup>th</sup>, 1915, to July 10<sup>th</sup>, 1915,  
 that I last saw him alive on July 10<sup>th</sup>, 1915, and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH \* was as follows:

Suo Volitio (Duration) yrs. mos. ds.Contributory  
SecondaryJ. J. Russell (Duration) yrs. mos. ds.  
(Signed) J. J. Russell M. O.July 10<sup>th</sup>, 1915 (Address) Eastport Md.\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place  
of death yrs. mos. ds. In the  
Where was disease contracted, State yrs. mos. ds.

If not at place of death?

Former or  
usual residence19 PLACE OF BURIAL OR REMOVAL Edwards Chapel DATE OF BURIAL July 11, 191520 UNDERTAKER Jas. S. Taylor Sons ADDRESS Annapolis Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscle*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 11128  
County. *A Arundel*

Village or City *Bumphreys Station* (No.)

2 FULL NAME *(still born)*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *colonial* 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
*(Write the word)* *Single*

## 6 DATE OF BIRTH

*7 1, 1915*  
(Month) (Day) (Year)

## 7 AGE

*0 yrs. 0 mos. 0 ds.* It LESS than  
1 day, *hrs.*  
OR *min. ?*

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work *wife*  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) *0*

## 9 BIRTHPLACE

(State or country) *A Arundel*

## 10 NAME OF FATHER

*William P. Rose*

## 11 BIRTHPLACE OF FATHER

(State or country) *0*

## 12 MAIDEN NAME OF MOTHER

*Sarah Cook*

## 13 BIRTHPLACE OF MOTHER

(State or country) *Md*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Wm P. Rose*

(Address) *Bumphreys Station*

## 15

Filed *July 3<sup>rd</sup> 1915* T. B. Horton M.D.

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. *34*

St. *0* Ward *0*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]



*Rose*

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*7 1, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
*July 1, 1915*, to *July 1, 1915*,

that I last saw *her* alive on *July 1, 1915*, and that death occurred on the date stated above, at *0* m.

The CAUSE OF DEATH\* was as follows:

*Breach confinement*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) *Thos B. Hale*, M. D.  
*July 2<sup>nd</sup> 1915* (Address) *W. W. Munroe*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

*Furnace Branch* DATE OF BURIAL *July 3, 1915*

## 20 UNDERTAKER

*Wm P. Rose* ADDRESS *Bumphreys Sta*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

*oma, Sarcoma, etc., of..... (name origin; "Can-*

*cer" is less definite; avoid use of "Tumor" for malig-*

*nant neoplasms); Measles; Whooping cough; Chronic*

*vascular heart disease; Chronic interstitial nephritis,*

*etc. The contributory (secondary or intercurrent)*

*affection need not be stated unless important. Ex-*

*ample: Measles (disease causing death), 29 ds.;*

*Bronchopneumonia (secondary), 70 ds. Never report*

*were symptoms or terminal conditions, such as "As-*

*thenia," "Anæmia" (merely symptomatic), "Atrophy,"*

*"Collapse," "Coma," "Convulsions," "Debility" ("Con-*

*genital," "Senile," etc.), "Dropsy," "Exhaustion,"*

*"Heart failure," "Haemorrhage," "Inanition," "Maras-*

*mus," "Old Age," "Shock," "Uraemia," "Weakness,"*

*etc., when a definite disease can be ascertained as the*

*cause. Always qualify all diseases resulting from*

*childbirth or miscarriage as "Puerperal septicac-*

*mia," "Puerperal peritonitis," etc. State cause for*

*which surgical operation was undertaken. For vio-*

*lent deaths state means of injury and qualify as*

*accidental, suicidal, or homicidal, or as probably*

*such, if impossible to determine definitely. Examples:*

*Accidental drowning; Struck by railway train—acci-*

*dent; Revolver wound of head—homicide; Poisoned*

*by carbolic acid—probably suicide. The nature of the*

*injury, as fracture of skull, and consequences (e. g.,*

*sepsis, tetanus) may be stated under the head of*

*"Contributory." (Recommendations on statement of*

*cause of death approved by Committee on Nomencla-*

*ture of the American Medical Association.)*

If this certificate is looked over thoroughly and all ques-

tions answered in detail, it will prevent further correspond-

ence. All the data is essential and must be obtained before

the certificate is permanently filed.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*

**RECEIVED**

AUG 5 1915

HUTCHINSON, V.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH 11124  
 County Anne Arundel

Village or City Crownsville State Hospital

2 FULL NAME John Summs

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDWED OR DIVORCED Married  
 (Write the word)

6 DATE OF BIRTH Unknown

(Month) (Day) , 1864

7 AGE 51

years. months. days.

If LESS than  
 1 day, hrs.  
 OR min. ?

8 OCCUPATION  
 (a) Trade, profession, or  
 particular kind of work  
 (b) General nature of industry  
 business, or establishment in  
 which employed (or employer)

Cook

9 BIRTHPLACE  
 (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER  
 (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER  
 (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital records

(Address)

15 Filed July 13, 1915 J. M. Welch

REGISTRAR

STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 21

[If death occurred in  
 a hospital or institution,  
 give its NAME instead  
 of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 11, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1915, to July 11, 1915, that I last saw him alive on July 11, 1915, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH \* was as follows:

Chronic valvular disease

Unknown (Duration) yrs. mos. days.

Contributory  
 Secondary

Death in Compensation (Duration) yrs. mos. days.

(Signed)

Robert D. Bonkerode (Address) July 11, 1915 Crooksville, Me.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 12 days. in the State, yrs. mos. days.

Where was disease contracted,

If not at place of death?

Former or usual residence Anne Arundel County

19 PLACE OF BURIAL OR REMOVAL

Annes Cemetery July 13, 1915

20 UNDERTAKER

J. & Sons

DATE OF BURIAL

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrubn*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Col-lapse," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uratnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmæ," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

RURFAT. T.V.S.

## MARGIN RESERVED FOR BINDING

1 PLACE OF DEATH

11125

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

County *Anne Arundel*Village or City *Marley*

(No.)

2 FULL NAME *John Spencer*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>Colored</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <i>Single</i>
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6 DATE OF BIRTH

*July* (Month) *1893* (Year)

7 AGE

*22* yrs.      mos.      ds.

If LESS than  
1 day,      hrs.  
OR      min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work *Laborer*
- (b) General nature of industry business, or establishment in which employed (or employer) *Construction*

9 BIRTHPLACE  
(State or country) *Maryland*10 NAME OF FATHER *James Spencer*11 BIRTHPLACE OF FATHER  
(State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Laura Richardson*13 BIRTHPLACE OF MOTHER  
(State or country) *Philadelphia*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *James Spencer*(Address) *Marley*

15

Filed *July 5*, 1915Signed *Howard H. Chapman*

Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *21*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 5* (Month) *1915* (Year)17 I HEREBY CERTIFY, That I attended deceased from *July 4*, 1915, to *July 5*, 1915,that I last saw him alive on *July 4*, 1915, and that death occurred on the date stated above, at *4 P.M.*

The CAUSE OF DEATH \* was as follows:

*Tuberculosis of lungs**WB*(Duration) yrs. *16* mos. *0* ds.Contributory  
Secondary(Duration) yrs. *0* mos. *0* ds.(Signed) *Howard H. Chapman*, M. D.July 6, 1915—(Address) *Baltimore*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place *Marley*      yrs. *0* mos. *0* ds.      In the *State*, *0* yrs. *0* mos. *0* ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence17 PLACE OF BURIAL OR REMOVAL *Magdalene*DATE OF BURIAL *July 7, 1915*20 UNDERTAKER *Olson*ADDRESS *Baltimore*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cod mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"; unqualified, is indefinite); *Tuberculosis of lungs, menin-*

*ges*, *periosteum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer," is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maraasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæma," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, U. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

11126

County Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist: No. 20

Village or City Lothian (No.)

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Philip Spriggs

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE Colored	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower (Write the word)
------------	-------------------------	---

6 DATE OF BIRTH

Unknown, 1  
(Month) (Day) (Year)

7 AGE

About 75 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work. None  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER	Thomas Spriggs
11 BIRTHPLACE OF FATHER (State or country)	Maryland
12 MAIDEN NAME OF MOTHER	Emma Cook
13 BIRTHPLACE OF MOTHER (State or country)	Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Spriggs  
 (Address) West River, Md

15 Filed July 2, 1915 — MacLean Coward  
 S. P. Cook REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 2, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
I did not attend, 1915, 1915,

that I last saw him alive on 1915,

and that death occurred on the date stated above, at 4:30 m.

The CAUSE OF DEATH\* was as follows:

Unknown Chronic Cardiac  
disease I think

(Duration) yrs. mos. ds.

Contributory  
Secondary

Unknown

(Duration) yrs. mos. ds.

(Signed) MacLean Coward, M. D.  
July 2, 1915 (Address) West River, Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Mt Zion, Md

DATE OF BURIAL

July 3, 1915

20 UNDERTAKER

John Thomas

ADDRESS

Lothian, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coat mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæma*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUL 7 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

County *G. G.*

11127

Village or City *Melrose* (No.)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *21*

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Susie Stevens*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*as he is*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

July 19, 1900

(Month)

(Day)

(Year)

7 AGE

15

yrs.

mos.

ds.

If LESS than  
1 day, .... hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work*S.S.*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)*Ind*

PARENTS

10 NAME OF  
FATHER*Susie Stevens*11 BIRTHPLACE  
OF FATHER  
(State or country)*Ind*12 MAIDEN NAME  
OF MOTHER*Mary May. P. K.*13 BIRTHPLACE  
OF MOTHER  
(State or country)*Ind*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*In Sharfalk.*

(Address)

*Melroseville Ind*

15

Filed *7/16/15**D. D. Pope*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 15, 1915  
(Month) (Day)  
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 4, 1914, to July 14, 1915...  
that I last saw him alive on July 14, 1915...and that death occurred on the date stated above, at 7409 m.,  
The CAUSE OF DEATH\* was as follows:*Septic Endocarditis.*

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. B. Gandy Jr.*, M. D.July 16, 1915 (Address) *Melroseville*\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCI-  
DENTAL, SUICIDAL, OR HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Edwards Chapel, Ind.* DATE OF BURIAL *7/16, 1915*20 UNDERTAKER *R. J. Williams Son*ADDRESS *Walesbury*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc. of ..... (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masculis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds.; *Bronchopneumonia* (secondary), 29 ds.; were symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traenita," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**RECEIVED**

AUG 6 1915

BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County.....  
a. a.

11128

Village or City.....  
Curtis Bay (No.)STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. ....

2 FULL NAME  
Charlie E. Taylor

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH  
July 31, 1883  
(Month) (Day) (Year)

7 AGE  
31 yrs. 11 mos. 7 ds.  
If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work.  
(b) General nature of industry  
business, or establishment in  
which employed (or employer)  
Conductor

9 SIRTHPLACE  
(State or country)  
Maryland

10 NAME OF  
FATHER  
Thos. H. Taylor

11 BIRTHPLACE  
OF FATHER  
(State or country)  
Md.

12 MAIDEN NAME  
OF MOTHER  
Ernie M. Williams

13 BIRTHPLACE  
OF MOTHER  
(State or country)  
Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant)  
Harry Hollis

(Address)  
Preston Md

15 Filed July 18, 1915  
J. B. Norton, M.D.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
July 20, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
191... to 191...  
that I last saw h. alive on

and that death occurred on the date stated above, at m.  
The CAUSE OF DEATH \* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

Contributory  
Secondary

James H. Fowler, acty coroner  
(Signature) July 28, 1915 (Address) Brooklyn, N. Y.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CRIMES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place  
of death yrs. mos. ds.  
Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL  
Preston, Md. July 21, 1915  
DATE OF BURIAL

20 UNDERTAKER  
Geo. A. Gerbig, Coffey & Payson  
ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *mени-*

*ges*, *peritonaeum*, etc, *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uratmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERFARIAL septicemia," "PUERFARIAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *ketosis*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 5 1915

A. T. V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		11129
County		a a
Village or City		Conways (No.)
2 FULL NAME		Doe Thomas
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
male	colored	married
6 DATE OF BIRTH		
		1,843 (Month) (Day) (Year)
7 AGE	81 1/4 yrs. — mos. — ds.	If LESS than 1 day, .... hrs. OR .... min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
(a) Farmer		
9 BIRTHPLACE (State or country)		
Maryland		
10 NAME OF FATHER		
Daniel Thomas		
11 BIRTHPLACE OF FATHER (State or country)		
Maryland		
12 MAIDEN NAME OF MOTHER		
Flora		
13 BIRTHPLACE OF MOTHER (State or country)		
Maryland		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)		
Liza Conlee (Address)		
15 Filed 7/27, 1915 REGISTRAR		

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 2

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July - 26 - , 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_, 1915, to July 24, 1915, that I last saw him alive on July 21, 1915, and that death occurred on the date stated above at 6:40 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart disease,

(Duration) 6 yrs. — mos. — ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) O H. McNeice M. D.  
July 26, 1915 (Address) Odenton Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSENTS OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Mt. Tabor C. A. Co. July 28, 1915

20 UNDERTAKER ADDRESS

P. J. Williams &amp; Son Waterbury

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm labore*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Convulsive," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *Septis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

<b>RECEIVED</b>
AUG 6 1915
<b>BUREAU, U.S.</b>

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11130

County A.A.STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Annapolis

1st

4 Market Street, St., Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Marian Agnes Tydungs

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

June 19, 1914  
(Month) (Day) (Year)

7 AGE

yrs. 13 mos.  ds. It LESS than  
1 day, \_\_\_\_\_ hrs.  
OR \_\_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHEREdward S. Tydungs11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHERLucy C. Brewer13 BIRTHPLACE  
OF MOTHER

(State or country)

Cambridge Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward S. Tydungs(Address) Annapolis Md.

15

Filed July 20, 1915 J. H. Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 19, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
July 18, 1915, to July 19, 1915,  
that I last saw him alive on July 19, 1915,and that death occurred on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH\* was as follows:

Acute Enteric Colitis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

John Paras, M. D.  
July 19, 1915 (Address) Annapolis Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. ds.

Where was disease contracted,  
It not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Cedar Bluff CentDATE OF BURIAL  
July 20, 1915

UNDERTAKER

Jas. J. Say Jr. Son

ADDRESS

Annapolis

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day Laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma

oma, *Sarcoma*, etc, of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masculosis*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *ictonus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 6 1915
BUREAU,V.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

County.....  
C.A.

11131

STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 24

Village or City

Sv. Balto. (No. 828 Pennington Ave)

St.; Ward)

[If death occurred in  
 a hospital or institution,  
 give its NAME instead  
 of street and number.]

2 FULL NAME

Anna J. Vyboukal

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
 MARRIED,  
 WIDOWED  
 OR DIVORCED  
 (Write the word)

Wifont

6 DATE OF BIRTH

Feb 28 (Month) (Day), 1915 (Year)

7 AGE

4 yrs. 4 mos. 10 ds. If LESS than  
 1 day, hrs.  
 OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
 particular kind of work  
 (b) General nature of industry  
 business, or establishment in  
 which employed (or employer)

Wifont

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Vaclav Vyboukal

(Address)

828 Pennington Ave

15

Filed July 11, 1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 10 (Month), 1915 (Year)

I HEREBY CERTIFY, That I attended deceased from  
 July 10, 1915, to July 10, 1915,  
 that I last saw her alive on July 10, 1915,  
 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH \* was as follows:

Endless Colds

(Duration) 4 yrs. 4 mos. 4 ds.

Contributory  
 SecondaryJohn B. Norton (Signature) yrs. mos. ds.  
 (Signed) July 11, 1915 (Address) Lewis Tamm 2nd\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
 CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
 SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
 OR RECENT RESIDENTS)At place of death yrs. mos. ds.  
 Where was disease contracted,  
 if not at place of death?Former or  
 usual residenceIn the  
 State, yrs. mos. ds.

19 PLACE OF BURIAL OR REMOVAL

Holy Cross (Signature) July 10, 1915 (Date)

20 UNDERTAKER

Lynn Bracken (Signature) ADDRESS  
 1904-6 Aspland St.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *malaria*,

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 5 1915

BUREAU U.S.A.



# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE causing DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of, . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tearus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
A. A. 11133

County.....

105-

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 25

Village or City Brooklyn (No. 600, Washington Ave., Ward)

2 FULL NAME  
Mary E. Walker

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) *Widowed*

6 DATE OF BIRTH Jan. 29, 1882

(Month) (Day) (Year)

7 AGE 33 yrs. 5 mos. 12 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country) Md.

Housewife

PARENTS  
10 NAME OF FATHER Benjamin Abbott

11 BIRTHPLACE OF FATHER Md.

12 MAIDEN NAME OF MOTHER Mary E. Hengel

13 BIRTHPLACE OF MOTHER Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. M. Cole

(Address) 8 S. Smallwood

15 Filed 7/14, 1915 C. H. Brooke

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 12, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, THAT attended deceased from June 9, 1915, to July 12, 1915, that last saw her alive on July 11, 1915, and that death occurred on the date stated above, at 6 A.M. The CAUSE OF DEATH \* was as follows:

Enteritis

Exhaustion (Duration) yrs. 3 mos. 3 ds.

Contributory Secondary

Tuberculosis (Duration) yrs. 1 mos. 3 ds.

(Signed) 7/12, 1915 (Address) 724 N. Carey St., M.D.

\* State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mss. ds. In the State, yrs. mss. ds.

Where disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cedar Hill

DATE OF BURIAL 7/14, 1915

20 UNDERTAKER H. M. Cole

ADDRESS Balto.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," "meningitis", unqualified, is indefinite); *Tuberculosis of lungs*, etc.

*ges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 20 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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RECEIVED  
JUL 27 1915  
NOV 8 1915

RECEIVED  
JUL 27 1915  
NOV 8 1915

BUREAU, V.S.

*Sent out to be signed  
on this form.*

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County *a. a.*  
Village or City *Glenarden*

11134

166

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *21*

2 FULL NAME

*Margrett Wallace*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word) *Widowed*

6 DATE OF BIRTH

*June 24, 1834*

7 AGE

*71 yrs., 1 mos., 0 ds.*If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)*None*9 BIRTHPLACE  
(State or country)*a. a. Co Md*

## PARENTS

10 NAME OF FATHER

*Workman*11 BIRTHPLACE OF FATHER  
(State or country)*Unknown*

12 MAIDEN NAME OF MOTHER

*Wintersaw*13 BIRTHPLACE OF MOTHER  
(State or country)*Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Isaac Queen*(Address) *Sage Bottom*

15

Filed *July 25, 1915 - Jms Welch*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*July 24, 1915*17 I HEREBY CERTIFY, That I attended deceased from  
191..., to 191...,

that I last saw h. alive on , 191...,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

*Accidental, (Burned to death.)**Congestion*

(Duration) yrs. mos. ds.

Contributory  
Secondary(Signed) *W H Mende Jr* (Address) *Castport Md*

(Duration) yrs. mos. ds.

(Address) *Castport Md*\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ADDRESS

*Sage Bottom* *July 25, 1915*

20 UNDERTAKER

*B J Hopkins Annapolis*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer," is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urtaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL sepihaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 6 1915

BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 11135  
County a-a-

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21

Village or City Annapolis (No. 58) St. North West St. 4 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Still Infant Washington

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE,  
~~MARRIED,~~  
~~WIDOWED,~~  
~~OR DIVORCED~~  
(Write the word) Single

## 6 DATE OF BIRTH

July 21, 1915  
(Month) (Day) (Year)

## 7 AGE

1 yrs. — mos. — ds. If LESS than  
1 day, .... hrs.  
OR ..... min. ?

## 8 OCCUPATION

- (a) Trade, profession, or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)

## PARENTS

## 10 NAME OF FATHER

James Washington

11 BIRTHPLACE OF FATHER  
(State or country)

Annapolis Md.

## 12 MAIDEN NAME OF MOTHER

Adella Sims

13 BIRTHPLACE OF MOTHER  
(State or country)

Annapolis Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Washington

## (Address)

North West St.

## 15

Filed July 22, 1915

J.W. Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 21, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
on July 21, 1915, to —, 191,

that I last saw him alive on —, 191,

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH\* was as follows:

Still birth

(Duration) yrs. mos. ds.

Contributory  
Secondary

Ambrose Grimes (Duration) yrs. mos. ds.  
(Signed) Ambridge, M. D.  
7-22, 1915 (Address) Annapolis, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL Auburn Cemt DATE OF BURIAL 7-23, 1915

## 20 UNDERTAKER

E.P.B. Parker & Son ADDRESS 92 West St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

Garcia

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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<b>RECEIVED</b>
AUG 6 1915
BUREAU, V.S.

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1 PLACE OF DEATH  
County Baltimore Md

11136

Village or City Baltimore (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 20

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Isabelle Weston

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Col</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
---------------------	----------------------------	--

6 DATE OF BIRTH <u>July</u>	<u>28</u>	<u>1915</u>
	(Month)	(Day)

7 AGE <u>yrs.</u>	<u>mos.</u>	<u>ds.</u>	If LESS than 1 day, hrs. OR min.?
-------------------	-------------	------------	---

8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u>	(b) General nature of industry, business, or establishment in which employed (or employer)
--	--

9 BIRTHPLACE (State or country) <u>Maryland</u>
--

10 NAME OF FATHER <u>John Watkins Jr</u>
---

11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>
--

12 MAIDEN NAME OF MOTHER <u>Maria Weston</u>
---

13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Signature) <u>John Watkins Jr</u>
--

(Address) <u>Baltimore Md</u>
-------------------------------

15 Filed <u>July 21, 1915</u>	MacLean Cawood My Local REGISTRAR
-------------------------------	--------------------------------------

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 21, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from I did not attend, 1915,

that I last saw him alive on \_\_\_\_\_, 1915,

and that death occurred on the date stated above, at \_\_\_\_\_, 1915.

The CAUSE OF DEATH\* was as follows:

unknown

(Duration) yrs. mos. ds.

Contributory unknown  
Secondary

(Duration) yrs. mos. ds.

(Signed) MacLean Cawood, M. D.  
July 21, 1915 (Address) Baltimore Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
It not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Baltimore Md DATE OF BURIAL July 22, 1915

20 UNDERTAKER Hanley & Hunt ADDRESS Baltimore Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fitterman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

11137

County Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

Village or City

Crownsville State Hospital

St.; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

2 FULL NAME

Maggie Wheeler

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Black

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Widowed

6 DATE OF BIRTH

Unknown, 1870

(Month) (Day) (Year)

7 AGE

45

Unknown

IT LESS than  
1 day, hrs.  
OR min.?8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work

Housework

(b) General nature of industry  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)

Maryland

10 NAME OF  
FATHER

Daniel Collins

11 BIRTHPLACE  
OF FATHER  
(State or country)

Maryland

12 MAIDEN NAME  
OF MOTHER

Rachel Lewis

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

15

Filed July 5, 1915 — Mrs Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

4

, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
October 8, 1914, to July 4, 1915,  
that I last saw her alive on July 4, 1915,  
and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH \* was as follows:

Chronic Intestinal Neuritis

(Duration) Unknown (mos.)

Contributory Secondary

(Duration) Unknown (mos.)

(Signed) Robert D. Miller, M.D.  
July 4, 1915 (Address) Greenville Md.\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place yrs. 8 mes. 26 ds. In the  
of death yrs. mos. ds. State, LifeWhere was disease contracted,  
if not at place of death?Former or  
usual residenceUnknown  
Baltimore County

19 PLACE OF BURIAL OR REMOVAL

Easton

DATE OF BURIAL

July 6, 1915

20 UNDERTAKER

J. W. Adams

ADDRESS

Annapolis

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always specify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms; so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Anne Arundel</u>		12171 <u>S</u>		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>21</u>	
Village or City <u>Solleys</u> (No.)				St.; Ward)	
2 FULL NAME <u>Wheeler</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>July 11, 1915</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>July 11, 1915</u> (Month) (Day) (Year)		17 I HEREBY CERTIFY That I attended deceased from <u>, 1915, to , 1915,</u> that I last saw <u>I</u> alive on <u>, 1915</u> , and that death occurred on the date stated above, at <u>m.</u>			
7 AGE <u>yrs. mos. ds.</u>	If LESS than 1 day, hrs. OR mid.?		The CAUSE OF DEATH was as follows: <u>Still - Birth</u> (Duration) yrs. mos. ds.		
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)		Contributory Secondary			
9 BIRTHPLACE (State or country) <u>Md.</u>		(Signed) <u>Shornall &amp; Bragshaw, M. D.</u> (Duration) yrs. mos. ds.			
10 NAME OF FATHER <u>Summerfield Wheeler</u>		11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>			
12 MAIDEN NAME OF MOTHER <u>Clara Helmstetter</u>		13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Summerfield Wheeler</u>					
(Address) <u>Solleys</u>		15 Filed <u>Nov 4, 1915</u> - <u>Shornall &amp; Bragshaw</u> Dip. Reg. Registrar			
16 If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.		17 PLACE OF BURIAL OR REMOVAL <u>Summerfield Wheeler Farm</u>		DATE OF BURIAL <u>July 11, 1915</u>	
20 UNDERTAKER <u>Summerfield Wheeler</u>		ADDRESS <u>Solleys, Md.</u>			

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**— Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Talor," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia"; unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

gesis

RECEIVED NOV 18 1915  
COPY SENT TO LOCAL REGISTRAR NO. 21 DATE

This certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED NOV 6 1915  
BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH County <i>Anne Arundel</i>		11138
Village or City <i>McKendree</i>		(No.)
2 FULL NAME <i>Eli Wiseman</i>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <i>Male</i>	4 COLOR OR RACE <i>Colored</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Mariid</i> (Write the word)
6 DATE OF BIRTH <i>unknown</i> (Month) (Day) (Year)		
7 AGE <i>78</i> yrs. mos. ds.	If LESS than 1 day, .... hrs. OR min. ?	
8 OCCUPATION <i>Farmer</i> (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE <i>Maryland</i> (State or country)		
10 NAME OF FATHER <i>unknown</i>		
11 BIRTHPLACE OF FATHER <i>Maryland</i> (State or country)		
12 MAIDEN NAME OF MOTHER <i>Rebecca Owens</i>		
13 BIRTHPLACE OF MOTHER <i>Maryland</i> (State or country)		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>John R. Wiseman</i> (Address) <i>McKendree, Md.</i>		
15 Filed <i>Jul 25, 1915</i>		A. H. Perrin REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *26*

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Hg

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 23, 1915*17 I HEREBY CERTIFY, That I attended deceased from *Sashings* to *at office* *July 23, 1915*,  
*months ago* that I last saw him *alive* on *July 23, 1915*.and that death occurred on the date stated above, at *8 P.M.*

The CAUSE OF DEATH\* was as follows:

*Mental Insufficiency &  
Cardiac dilatation*

(Duration) yrs. mos. ds.

Contributory *unknown*  
Secondary

(Duration) yrs. mos. ds.

(Signed) *MacLane Wood*, M.D.  
*Jul 25, 1915* (Address) *West River, Md.*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL *Union Chapel, Md.* DATE OF BURIAL *Jul 25, 1915*20 UNDERTAKER *Bob Wood* ADDRESS *Friendship*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer-Coat minic*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1915

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11139

County

Anne Arundel

Village or City

Rofinsons (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James Samuel Wood

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Colorful	

6 DATE OF BIRTH

July 16, 1905

(Month) (Day) (Year)

7 AGE

Stillborn

yrs. mos. ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

James Wood

11 BIRTHPLACE OF FATHER

Virginia

12 MAIDEN NAME OF MOTHER

Sedovine Hartman

13 BIRTHPLACE OF MOTHER

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Wood

(Address)

Rofinsons

15

Filed July 17, 1915

Thomas J. Jennings  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 16, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw h alive on , 191...

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Thomas J. Jennings, M. D.

July 17, 1915 (Address) Glen Burnie

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSPORTS, OR RECENT REBIDENTS)

At place Where was disease contracted, In the State, yrs. mos. ds.

of death yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Glen Burnie

DATE OF BURIAL

July 17, 1915

20 UNDERTAKER

Thomas Jennings  
Rofinsons

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composition*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*; *Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"); unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

